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ABSTRACT

This document provides witnesses' testimonies and prepared statements from the Senate hearing called to examine the problems of catastrophic health care costs. Statements are included from Senators John Melcher, Quentin Burdick, Larry Pressler, John Heinz, and Pete Wilson. Prepared statements are included from Senators David Pryor and Charles Grassley. Joan Yelineck, Edith Reiger, and Helen Fish testify, describing their experiences with the devastating health care costs and the sacrifices they have made to obtain adequate health care for their relatives. Robert Shapland, Mutual of Omaha Insurance Company, testifies on behalf of the Health Insurance Association of America. Other relevant testimonies, comments of Consumers Union on "Catastrophic Illness Expenses," the Department of Health and Human Services Secretary Otis Bowen's report to the President; and a White House fact sheet, "The President's Initiative on Catastrophic Illness Coverage" are appended. (NB)

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CATASTROPHIC HEALTH CARE COSTS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

WASHINGTON, DC

JANUARY 26, 1987

Serial No. 100-1

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CATASTROPHIC HEALTH CARE COSTS

MONDAY, JANUARY 26, 1987

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee convened, pursuant to notice, at 10:20 a.m., in room SD-562, Dirksen Senate Office Building, Honorable John Melcher, chairman of the committee, presiding.

Present: Senators Melcher, Heinz, Burdick, Pressler, and Wilson.

Staff present: Max I. Richtman, staff director; James Michie, chief investigator; David Schulke, investigator; Michael Werner, counsel for investigations; Stephen R. McConnell, minority staff director.

OPENING STATEMENT BY SENATOR JOHN MELCHER

Chairman MELCHER. The committee will come to order.

We are meeting today to examine the problems of catastrophic health care costs. So we have three witnesses who will describe to us their experiences with these devastating health care costs, and the many sacrifices they have made in order to obtain adequate health care for their loved ones.

More than 15 percent of the elderly in the United States, those over 65, have incomes that are equivalent to the poverty line or less. If they are not on Medicaid, they have to pay their monthly Medicare premiums; they have to pay for all drugs prescribed outside of the hospital. Altogether, the elderly spend $30 billion out of their own pockets each year for health care coverage and protection. That is about the same as what they were paying, maybe slightly higher, than before Medicare was enacted.

There is a fear among the elderly in particular of the cost of health care dragging them down and down financially, to where they are forced to rely on Medicaid. This certainly runs counter to the American concept that the elderly ought to be able to live in decent comfort and dignity and enjoy their so-called "golden years."

This committee intends to vigorously prod the Congress into solving this very serious problem of catastrophic health care costs.

First of all, the elderly need to know exactly what Medicare will pay for and what it will not pay for. I believe that is our responsibility here in the Aging Committee to make sure that the Department of Health and Human Services clearly states, in language that is easily understood to those on Medicare, exactly what will be covered and what will not be covered.

Second, I think the private insurance companies sometimes are less than definite and less than clear on just what their "Medigap" policies cover. I think it is essential for the holders of these policies to be able to clearly understand what they are paying for, what they can receive in benefits, and how it blends in with Medicare.

Finally, we must provide peace of mind to the thousands of Americans who are frightened by the catastrophic costs that result from debilitating health conditions.

So this morning, we are holding our first hearing on catastrophic coverage, and on Wednesday we will meet jointly with the House Aging Committee over in the Cannon Building, at 2 o'clock. At that time, we will hear from Dr. Bowen, Secretary of the Department of Health and Human Services, who will discuss with us his proposal for catastrophic coverage.

The witnesses we are going to hear from today will tell us in their own words how they are afflicted, but before we turn to them, Senator Burdick, do you have an opening statement?

STATEMENT BY SENATOR QUENTIN N. BURDICK

Senator BURDICK. Mr. Chairman, I want to thank you and congratulate you for calling this hearing on catastrophic health care. It is a deep concern of mine and of my constituents in North Dakota. In fact, several years ago, I held a field hearing in Bismarck, North Dakota, on the future of long-term care. Many of the questions raised then remain unanswered.

Today, 28 million Americans are 65 or over, and the elderly are the fastest growing segment of our society. The elderly population doubled between 1950 and 1980, and it's expected to double again in the next 40 years. The number of "old-old," those aged 85 or over, will increase by 75 percent before the end of the century, from 2.8 million to 4.9 million. The need for long-term care among this age group can only be expected to increase accordingly.

Nursing home expenditures totaled a staggering $35.2 billion in 1985. The figure for 1986 is closer to $39 billion. When we break the totals down, we find that the average cost of a year's stay in a nursing home is $25,000. Right now, patients are paying over half of the cost out of their own pockets.

A recent survey of the elderly found that nearly two out of three live alone, and over a third of all households age 66 and older would be impoverished after only 13 weeks of nursing home care. By the end of a year, the figure grows to 83 percent.

Just who are we talking about here? Nearly 16 million Americans, or about one family in five, incur "catastrophic" out-of-pocket medical costs every year. And, unfortunately, insurance hasn't come up with the answer yet—premiums can run as high as $1,451 a year per person. This is simply not affordable for most of our Nation's elderly, who rely on fixed incomes.

Even for those who can afford "Medigap" insurance, it turns out that most policies go no further than Medicare. They effectively provide no coverage for nursing home stays.

The burden has been falling onto Medicaid so far, but this system is far from perfect. Before Medicaid will pay, patients must

be poor, or must "spend down" their assets to meet the eligibility standards.

Clearly, we have a problem of enormous proportions. I am as committed as you to finding a workable solution, so that those in our society who have worked all their lives can maintain their dignity and enjoy the independence that is rightfully theirs.

Thank you.

Chairman MELCHER. Thank you, Senator.

Currently, there is a debate concerning the definition of catastrophic cost. For instance, we have been led to believe by some insurance companies that catastrophic costs occur mainly after a patient receives hospital care for many years. In addition, Dr. Bowen's proposal for catastrophic coverage completely leaves out long-term health care whether it is provided in a nursing home or in the patient's home.

I think it is important to avoid this misconception and realize that catastrophic costs can arise from a variety of circumstances. I think these witnesses can help us, therefore, because they will explain their circumstances, and that will help us better understand the causes of catastrophic medical costs.

Senator Pressler, can you give us some advice?

STATEMENT BY SENATOR LARRY PRESSLER

Senator PRESSLER. First of all, thank you very much, Mr. Chairman, for holding these hearings. I apologize for being late, but I had to fight through this snow blizzard greater than many I find in South Dakota.

Before I begin my remarks, I want to express my best wishes to you, Senator Melcher, as the new Chairman of this committee for the 100th Congress. I look forward to working closely with you and the ranking member, Senator Heinz, my good friend, Senator Burdick, and others on many issues concerning the aging of our population.

Coming from a rural Midwestern State, I hope we can work specifically on some of the very unique problems of our elderly population in those rural areas.

However, today we are here to examine a problem that affects our senior citizens across the Nation—catastrophic health care costs.

I commend you, Chairman Melcher, for tackling such an important issue in our first official hearing of the new Congress. I am sure we all agree that access to catastrophic care coverage is one of the most pressing problems facing our Nation today. South Dakota ranks sixth in the Nation for the highest percentage of senior citizens in its population. Over 14 percent of South Dakota's citizens are elderly. Many of the letters I receive in my office and the people I talk to in my State tell me they simply cannot afford health care anymore.

Most people do not understand why Medicare does not cover all of their medical bills. Many individuals purchase Medigap insurance under the belief that they will be covered in areas where Medicare falls short. I am sure this is a familiar scenario, not just in South Dakota but across the country.

So the question before us is how do we provide adequate access to health care for all individuals in need. And the biggest aspects of this problem are catastrophic and long-term care.

The elderly account for one-third of all personal health care expenditures even though they constitute only 11 percent of our total population. We need to find a fiscally responsible way of providing adequate health care coverage now, because senior citizens constitute the only segment of our population that is going to significantly increase in the coming years.

I have spoken to many people about this problem, and many can take care of most of their health care problems. But, when a family experiences a catastrophic health care problem, particularly a senior citizen, that is when they find out their private insurance, or Medicare does not cover enough. That is when they lose their personal property and what they have saved for all their lives—that is truly a catastrophic experience.

So I thank the Chair for this hearing, and I look forward to hearing our witnesses.

Chairman MELCHER. Thank you very much.

Senator Heinz, we are delighted you are here and would like to hear from you now.

STATEMENT OF SENATOR JOHN HEINZ

Senator HEINZ. Mr. Chairman, first let me commend and congratulate you and the committee for holding this hearing. I think this is probably one of the few organized events taking place in Washington, DC today, and it could not be on a more vital or appropriate subject, namely, catastrophic care.

This is the first hearing of this committee in the 100th Congress, and the issue that you choose to address darkens the door of far too many Americans, and that of course is the specter of catastrophic acute or long-term illness.

For over two decades, since the birth of Medicare and Medicaid, Congress has pursued a policy of medical insurance protection for our oldest and our most economically vulnerable citizens. But these two programs, as the front line of defense against financially crippling medical costs, while they have had many successes also have their fair share of shortcomings.

Almost 100 percent of elderly Americans benefit from hospital insurance under Medicare while only 4 in 10 previously had such coverage. Mortality rates for both elderly women and men dropped sharply in the decade immediately following the implementation of Medicare—a reflection, in part, of better access to care.

But progress is only a measure of what still needs to be done. More than one Aging Committee hearing has shown the effect of creeping out-of-pocket costs on access and quality. We have heard testimony before from families devastated by long-term illnesses and, frankly, dumbfounded by the maze of regulations, restrictions and limitations in private insurance coverage.

Yet, once again, Mr. Chairman, we will hear testimony this morning on the shortfalls of our health care programs, on the loopholes and potholes, the financial, psychological and physical "black holes" that put too many Americans at risk.

I think we stand at a crossroads. Our choice is to strengthen and expand our commitment to provide essential health care services for all Americans or, in the alternative—which I hope we do not do--to cave in to compulsive budgeteers and program polemics who say we have done enough already.

I think the choice is clear, and I think Secretary Bowen, whom we will hear from later this week, deserves credit for steering the public debate down the right road with his proposal for catastrophic coverage.

But I offer one caveat as Congress and all of us take up the issue of catastrophic coverage, and that is this—that we should avoid stopping short of a solution that is truly comprehensive. We have to provide for a full range of services, from community-based to institutional, from catastrophic acute to long-term care. We need a solution, in other words, that protects against the impoverishment of individuals and their families, that assures access to care without regard to ability to pay, and for Americans of all ages. Most of all, we need a solution which includes incentives for cost containment which do not threaten quality.

The people, Mr. Chairman, that you have invited to this hearing today are themselves or represent people who, for in excess of six decades, have been proud, self-sufficient people, taking care of themselves and their own.

It is a national tragedy that, beset by an illness, a sickness, that a huge excess of hospital or nursing home bills should plunge such an individual, such a family, from a plateau of self-respect into an abyss of dependency and desperation. And it is my hope that out of these hearings that you have called, Mr. Chairman, we will be able to assure that people are protected from falling into the chasm, and that instead of having a crash landing, there will be a much happier ending.

Thank you, Mr. Chairman.

Chairman MELCHER. Thank you very much, Senator Heinz.

Senator David Pryor and Senator Chuck Grassley cannot be with us today due to prior commitments. They have, however, submitted statements for the record, and without objection, they will be inserted at this point.

[The prepared statements of Senators Pryor and Grassley follow:]

OPENING STATEMENT OF HON. DAVID PRYOR

Mr. Chairman, I'd like to congratulate you on the scheduling of this hearing. Catastrophic coverage seems to be the issue of the hour—the newspapers are filled with articles of it, and this week alone several Congressional committees have scheduled hearings on the topic. This is a significant change since last August when I held an Aging Committee hearing on this topic in Arkansas, and found limited hearing reference to the issue during recent Congresses. I hope that this increased attention will translate into some positive legislative action this year.

It is no secret that HHS Secretary Otis Bowen is to be credited for a great deal of the attention being focused in the area of catastrophic health care costs. Although through the years there have been a number of legislative proposals submitted to deal with one or more aspect of the catastrophic problem, the Secretary's endorsement of a catastrophic plan and subsequent Advisory Committee meetings started many of the interested parties talking. Equal in importance, however, is the definition for "catastrophic" that the Secretary's Advisory Committee came up with—a disease or condition was defined as catastrophic based on its financial impact upon an individual or a family. This is much broader approach than had been previously taken, one which includes three distinct problem areas: acute catastrophic care for

the elderly, long-term health care coverage for the elderly; and long-term and catastrophic health care coverage for individuals of all ages. I believe the Congress must retain this broad approach in order to make any significant inroads in dealing with this problem.

ACUTE CATASTROPHIC CARE FOR THE ELDERLY

The first of these areas—acute catastrophic coverage for the elderly—is the area which can be most readily addressed. The major options include:

Improvements to current national Medigap policy and more stringent enforcement of laws regarding these policies; and/or

Expansion of the Medicare program to fill the most glaring acute care gaps.

The latter is part of Secretary Bowen's plan. The relative ease with which this problem can be addressed does not imply a lack of importance—the gaps in acute care coverage have been serious problems since Medicare's inception which can financially devastate an elderly individual or couple. In fact, that has been exactly what has happened to around 5 percent of the Medicare population, and the other 95 percent live in fear of that occurring. Nor are these options free of controversy, as I believe we will hear from the insurance industry today.

ACUTE/MINIMUM COVERAGE FOR ALL AGE GROUPS

The elderly have no monopoly on health care needs or expenses. A major problem this nation must face is that of uncovered care—individuals and families who have no health insurance coverage whatsoever. Around 18 percent (35 million) of the under 65 population have no health care coverage. We must work to create greater incentives for participation in group health insurance programs and to make federal programs more responsive to these needs.

LONG TERM CARE FOR THE ELDERLY

Finally, the area of long term care coverage for the elderly must be examined. There are a number of changes which are needed to clarify benefits in this area—particularly in the home health and Medicare nursing home benefits areas. We must also fully examine the concept of long term care and nursing home insurance. There are some serious concerns about the wisdom of marketing long term care policies on a large scale—particularly about the funding of such an expensive product.

Frequently I hear of elderly couples who both have serious health problems—where one must sacrifice attention to his or her own health care needs in order to finance care for the other. This type of situation is unconscionable, and we have an obligation to address it. The area of spousal impoverishment has not received sufficient attention. This occurs when one member of an elderly couple is placed in a nursing home or needs other expensive health care and the community property is liquidated in order to pay for the necessary care, leaving the spouse in the community destitute. We need to find a workable way wo limit liability in situations like these.

Mr. Chairman, by the conclusion of the President's State of the Union message tomorrow night we will have a much better idea what the Administration has in mind in the way of catastrophic health legislation. I know that there is much that can be done, and as a member of this Committee, as well as the Health Subcommittee of the Senate Finance Committee, I plan to be actively involved in the debate on the issue. The implementation of a truly comprehensive national catastrophic plan may take a number of years, but the prospects are more hopeful now than ever before to accomplish some meaningful reform in this area. I stand ready to work with my colleagues toward that goal.

STATEMENT OF SENATOR CHARLES E. GRASSLEY AT A HEARING OF THE SPECIAL COMMITTEE ON AGING ON THE TOPIC OF CATASTROPHIC HEALTH CARE COSTS

Thank you Mr. Chairman.

I commend you for having this early hearing on the problem of catastrophic health care expenses and for planning several other hearings on this topic. Clearly, there is a great deal of interest in it here in the Congress and nationally as there should be. Clearly also, it is a complex topic and we ought to give it the time and careful treatment it deserves.

There has already been a great deal written about the threat of both acute and long term care catastrophic health care costs to the elderly, about what seems to be

a growing lack of health insurance coverage among the general population, and about the problem of the uninsurable. I hope that, with this hearing, we start the process of arriving at some kind of rough consensus on the dimensions of the problem and how to proceed.

I sincerely hope that we proceed carefully, especially as concerns any temptation to create new Federal benefit programs. In the first place, we still have a minor deficit problem, which, as far as I can tell, the Congress, the administration and the American people are committed to eliminating.

Furthermore, and in my opinion, equally important, we need to be careful that we do not promise things to the American people that we may not be able to deliver. As one of our witnesses points out in his testimony, we are not now delivering on what we have already promised to deliver through the Medicare Program. Recent financing crises in the Social Security Retirement Program, although we have repaired that problem, and in the Medicare Program, have helped to create lack of confidence on the part of the American people in the promises their elected representatives make to them. More undeliverable promises can only create more disaffiliation and political discontent.

I am pleased that the committee is seeking out the perspective of private business people with respect to what they can offer to the solution of this problem. It seems clear, at least to me, that, given our deficit problem and the unpopularity of a general increase in income taxes, we will need the help of the private sector in solving this catastrophic health care expense problem.

That is all I have to say for the present, Mr. Chairman. I look forward to the testimony of our witnesses.

Chairman MELCHER. The first witness we are going to hear from is Mrs. Joan Yelineck, of Beaver Dam, WI.

Mrs. Yelineck, will you come to the witness table, please?

STATEMENT OF JOAN YELINECK, BEAVER DAM, WI

Mrs. YELINECK. Senator Melcher, before you start asking me some questions, may I thank you very much, and all the other Senators, Mr. Michie and all the aides over there for the wonderful work you are doing. I am speaking for an awful lot of friends who are in the same boat that my husband and I are in. I cannot thank you enough.

Chairman MELCHER. Would you tell us, Mrs. Yelineck, what is your husband's current condition?

Mrs. YELINECK. I would have to give you a little bit of background on my husband. My husband spent 21 years' service in the Government—10 years at U.S. Weather Bureau, and then after World War II he went back to school and became a deputy collector for Internal Revenue and worked up to be a special agent.

Then he decided he would like to open his own practice, which he was in for about 21 years, self-employed. You have no retirement, you have no medical support, et cetera.

And unfortunately, that was when March 15 was the deadline for filing; he suffered a myocardial infarction, which is a heart attack that destroys the main muscle of the heart. And he was not a candidate for surgery, because he has also obstructive pulmonary disease and an aneurism.

Chairman MELCHER. What year was that?

Mrs. YELINECK. His illness started 7 years ago.

Chairman MELCHER. Seven years ago; and the heart attack occurred 7 years ago?

Mrs. YELINECK. Yes; and then the obstructive pulmonary disease, and the aneurism below his navel, which is inoperable.

Well, we had a lovely home on the lake—I have a picture of it—a lovely, lovely home. We were frugal; we had put aside in invest-

ments for our retirement. I might get a little bit emotional over this because I have just been out of the hospital a short time where I have had to have surgery.

We had to sell our home and move into a small apartment. And our income—we had to divest of the investments for living expenses monthly. My husband receives $448 per month Social Security, and I, $190, because wife working for husband at that time—maybe this law has been changed since then.

Our medical bills alone—I would like to correct myself, sir—our drug bills, our pharmaceutical bills alone for the last 5 years have totalled—I called the pharmacy for the total—it is $5,720.

My husband has figured out that 30 percent of our income goes out for medical expenses that we are not reimbursed for by Medicare or our supplemental medical insurance. Our supplemental policy stated that my husband, after spending 3 days in the hospital, would qualify for nursing home care. Well, now, in little print, I have had four legal people look at this, and they have said, "It is very ambiguous. We cannot answer that."

However, I have contacted one of the agents, and they are coming next week to see if we really do. In the meantime, I got a bill last Tuesday—oh, I am missing a very important point here, Senators.

I have been taking care of my husband all this time, and he has been in need of 24-hour care, because he also developed an injury in his neck where the sixth and seventh vertebrae, the disc has slipped, and the vertebrae have pushed the nerves out, which sends terrific pain down the neck and down the arm. He was on 16 aspirin, 8 extra-strength Tylenol plus codeine. Well, that can ruin anybody's stomach within 4 days.

He was taken into the Beaver Dam Hospital, and they said, "There is not anything much we can do." But some nurse spoke up and said, "Let us try TENS, Doctor. What do you think?"

TENS is an abbreviation for transcutaneous electro-nerve stimulation. You are hooked up just like in telemetry, if you have seen anybody in cardiac care, and a little instrument hangs in front of you on your garment, and that has a battery in it. It is very similar to a stun gun. The patient turns the little wheels until they can feel a shock going through their body. This shock sends a message to the brain to pull out a hormone which is stronger than morphine. It is actually a very wonderful invention. Some people can only tolerate it for an hour to 2 hours. My husband is tolerating it for 24 hours.

I was sent home after 3 days in the hospital with him all wired up as such. Nobody instructed me how to handle this, and at 2 o'clock in the morning the thing went haywire and almost bounced him out of bed. And I had to get out an instruction book and go through it and find out what I do next at 2 o'clock in the morning. I managed that. So he is all hooked up with this.

Well, this went on for 6 weeks, needless to say, day and night. And I collapsed, and I was taken by emergency to Saint Mary's Hospital in Madison, where I had to have surgery. Well, what to do with my husband?

My husband then was sent to Clearview, a nursing health care facility. And they tell me that he does not qualify for Medicare be-

cause he is not in need of 24-hour skilled nursing; and yet this man cannot do anything.

And having taken out this supplemental insurance for nursing home care, we felt that he was covered. So he has put in an appeal. I do not know how far we are going to get with this appeal, but I am not going to pay it until there is an appeal. I do not have the money to pay it.

Chairman MELCHER. Mrs. Yelineck, there have been 7 years, then, of increasing health problems with your husband. Do I understand you correctly that you are now paying 30 percent of your income for health care, whether it is prescriptions or what-have-you?

Mrs. YELINECK. Yes, sir.

Chairman MELCHER. That is over and above Medicare and your insurance coverage?

Mrs. YELINECK. Yes, sir. The down payment on our home has all gone for that.

Chairman MELCHER. If I understand you correctly, the costs have increased for your husband during the past 12 months; is that correct?

Mrs. YELINECK. Oh, yes, you are very correct, sir. And this is all from his care at the University of Wisconsin Hospital and Clinic, and these are the bills from 1985 and 1986.

Chairman MELCHER. Are they paid?

Mrs. YELINECK. No. Thank God for an auditor on the Commission on Aging, who comes and helps me every 3 weeks go through these bills. There are terrible discrepancies in them. One bill will say you owe $3,000, another one says you owe $2,100.

Chairman MELCHER. The 1985 bills are not paid yet?

Mrs. YELINECK. Yes, 1985 and 1986.

Chairman MELCHER. Have not been paid?

Mrs. YELINECK. Some of them are paid, and some are not.

Chairman MELCHER. Now you have had some of your own health problems.

Mrs. YELINECK. Those bills just started coming in last week.

Chairman MELCHER. Do you mind telling us if you and your husband can financially cover the costs that you are facing right now?

Mrs. YELINECK. Oh, no, there is no way, Senator, no. I would have to turn to my brother who is an old salt, living out on his boat in Key West, FL. I hate to do that.

Chairman MELCHER. You would get help from him?

Mrs. YELINECK. There would be the possibility. He is 77 years old.

Chairman MELCHER. And your husband, I see, is 73; is that correct?

Mrs. YELINECK. Yes, he is 73.

Chairman MELCHER. And you are 68?

Mrs. YELINECK. Yes, sir.

Chairman MELCHER. Well, just tell us what this means to you, or what you recommend that we do, because you apparently will be able to pay these bills with the help of your brother; is that right?

Mrs. YELINECK. Oh, I should not have said that; no, no.

Chairman MELCHER. What do you mean?

Mrs. YELINECK. Well, it would be asking him to give up whatever he might have, and I do not think that is right to do that.

Chairman MELCHER. What are the costs; can you give us a figure per month——

Mrs. YELINECK. Right now, which is outstanding?

Chairman MELCHER. Well, outstanding first, yes.

Mrs. YELINECK. That is very hard to do. I called the University Hospital Clinic where they issue the Medicare assistance and asked them if they please would send me an accounting over the last 5 years on what doctor and clinic and hospital costs were. They said, "We cannot do that." And I said, "Oh, but yes, you can."

They said, "Well, you have to send in a written request."

I said, "I will have it in the mail today," which I did. I specifically asked if they would please answer this at the latest by January 20. I had no response from them at all.

Chairman MELCHER. Well, do you have any idea what is left to be paid?

Mrs. YELINECK. Well, it would be so hard to say because there has been such an accumulation of it within the last 8 weeks. I would be speaking in the thousands.

Chairman MELCHER. $5,000? $2,000?

Mrs. YELINECK. I would say around $3,000 to $4,000, perhaps.

Chairman MELCHER. $3,000 to $4,000 is still unpaid?

Mrs. YELINECK. Oh, yes. I was so hoping to have those figures for you so I could have been more accurate on that.

Chairman MELCHER. How will you pay that?

Mrs. YELINECK. Well, we made an agreement—this sounds ridiculous—we have had threatening letters from them when we could not pay and threatening telephone calls—so we made an agreement to pay $25 per month in good faith. Well, now, I have not been able to do that.

Chairman MELCHER. Are all your savings gone?

Mrs. YELINECK. Yes, every bit.

Chairman MELCHER. All of them?

Mrs. YELINECK. All.

Chairman MELCHER. And what are your remaining assets? Do you own a house?

Mrs. YELINECK. Oh, no. Our home is gone.

Chairman MELCHER. Your home is gone, also?

Mrs. YELINECK. Yes, and our car is 12 years old.

Chairman MELCHER. The monthly costs for your husband, if not met by Medicare, are going to be around $2,000 or more?

Mrs. YELINECK. The bill that I got last week was $2,990 from them.

Chairman MELCHER. For how long a period?

Mrs. YELINECK. Thirty days. And that does not include his oxygen or his medication.

Chairman MELCHER. So it is something in excess of $3,000 a month, then?

Mrs. YELINECK. Yes, sir. This, I am just going to hold up, is the medication receives at 10 a.m., nine different ones; 4 p.m., 10 p.m., 4 a.m., 2.a.m., and then 4 p.m. and then 6 a.m., around-the-clock.

Chairman MELCHER. So in sum, all of your preparation for retirement and protection against costs has just evaporated, including your home?

Mrs. YELINECK. Yes, sir.

Chairman MELCHER. And the costs continue, at at least $3,000.

Mrs. YELINECK. Yes.

Chairman MELCHER. How about your own health? You look very fine, I might tell you, Mrs. Yelineck.

Mrs. YELINECK. Well, thank you. I have been told that, but you know, your face can make a liar out of you, too. I have had four major abdominal surgeries, where I had a tumor as large as a loaf of bread removed from my abdomen. As a result of that, peristaltic action happens, where you do not digest your food; the worm-like movement of your intestines stops completely. Then, I am rushed to Madison, where a gastroenterologist said, "Oh, you can go around bragging you had the same thing done that President Reagan had done." And I said, "Well, I do not care to brag about that." But that is called an endoscopic.

I was so ill that—I am Catholic—and a priest was called to anoint me, which is the last sacrament of the church for the ill. Then I was operated on the next morning. That was about 7 weeks ago, so I am really not doing my best right here in recalling.

Chairman MELCHER. Were those bills settled yet?

Mrs. YELINECK. No. They are just coming in. One that just came in was $2,000. That was for part of the surgery.

Chairman MELCHER. But some of that will be paid by Medicare, will it not?

Mrs. YELINECK. It all depends on how they approve it.

Chairman MELCHER. So there is no certainty right at this moment.

Mrs. YELINECK. No; there never is. There never is until you get the statement from Medicare, saying what they approve and what they do not approve.

Chairman MELCHER. Well, Mrs. Yelineck, I repeat, you do look very well. I would never have guessed that you have had serious surgery in the last few months.

I want to thank you very much personally for coming here over this weekend. You must have come in on an early flight yesterday, or were you wise enough to come on Saturday?

Mrs. YELINECK. It was a little hairy. My daughter came with me, and there was a heavy gentleman sitting on the end of the row, and he was reading a book. He noticed that I was really getting very nervous, and he asked me, "Are you praying?" And I said, "Yes, I am." And he said, "Well, I am a priest. I will pray with you."

So I came on a wing and a prayer.

Chairman MELCHER. Well, thank you very much.

Senator Heinz.

Senator HEINZ. Thank you, Mr. Chairman.

Mrs. Yelineck, I join the Chairman on congratulating you on having gotten here somehow and on your tremendous fortitude and courage in persevering through what you have been through for the last 7 years.

As I understand it, you have not only liquidated all your savings, but you had to sell your house in order to pay the medical bills you have referred to; is that right?

Mrs. YELINECK. Exactly sir, yes.

Senator HEINZ. And so you are broke?

Mrs. YELINECK. We are broke.

Senator HEINZ. And you are in debt——

Mrs. YELINECK. Yes, yes.

Senator HEINZ [continuing]. To nursing homes, to hospitals, to doctors.

Mrs. YELINECK. I have no idea how much we are in debt, though. I would have had those figures, as I told Senator Melcher, if the University Hospital Clinic would have come through with what I requested.

Senator HEINZ. What are you going to do if these $4,000 or $5,000 worth of bills that you have described, that everybody says, "Well, you have to pay us"—what are you going to do?

Mrs. YELINECK. I do not know, I do not know. And my husband is of very sound mind—well, his background will tell you, having been a special agent for the Internal Revenue. He is very anxious to get out of the nursing home. God love you, I hope none of you ever have to be in one.

Senator HEINZ. He does not want to be in the nursing home?

Mrs. YELINECK. Oh, no.

Senator HEINZ. He is unhappy there?

Mrs. YELINECK. Oh, very, very.

Senator HEINZ. Why is that?

Mrs. YELINECK. He is the only sane one in a room with four patients. It is pretty hard—nobody to talk sports with, nobody to talk football with, nobody to talk baseball with, nobody to talk anything with.

Senator HEINZ. You are saying he is in a lot better shape than the other three people there?

Mrs. YELINECK. Oh, well, he just read Lee Iacocca's book; he just read Carl Sagan's Cosmos, to give you a little idea of the type of man he is.

Senator HEINZ. Well, I was asking about the other three people in the room, I gather, they are in pretty bad shape?

Mrs. YELINECK. Yes, very bad shape.

Senator HEINZ. Are you in such a condition yet that you have had to or you anticipate putting off necessary medical care either for yourself or for your husband?

Mrs. YELINECK. I have done that, Senator Heinz, for the last 5 years. And the doctors have warned me, "If you do not come in and have a complete physical so we can get to the bottom of all this, your husband is going to be living, and you will be gone."

Senator HEINZ. This was 5 years ago?

Mrs. YELINECK. No. This was just 8 weeks ago.

Senator HEINZ. What does your doctor want you to do, and what do you feel you cannot afford to do?

Mrs. YELINECK. Well, they are talking about another exploratory surgery in my intestines, because I am also afflicted with endometriosis, which is a contamination of the pelvic region. I cannot see doing that, because that would just leave Don.

Senator HEINZ. So you are faced with having to give up some medical care that you need in order to have enough left to live and take care of your husband. That is really what you are saying to us, isn't it?

Mrs. YELINECK. Exactly, yes.

Senator HEINZ. What about Medicaid? You know, there is a program for people who are in great need and destitute. Are you eligible, do you know?

Mrs. YELINECK. I have not gone into that. I do not know anything about it, really. The little I do know is that it is some kind of help for medical expenses.

Senator HEINZ. But you have not looked into that?

Mrs. YELINECK. No.

Senator HEINZ. Have you asked anybody about it? Have you talked to the hospital or the doctors or a social worker or anybody?

Mrs. YELINECK. No. This all came on so quickly with me. I had been taking care of my husband, as I said before, and I have had nurse's training, so I was acquainted with how to handle his pulmonary spasms when he goes into them. It is the same sensation as a person drowning. I know how to increase his oxygen or decrease it; if you increase it too much, you can blow their heads off, and you build up a carbon dioxide in the body which is poisonous, and it would be instant death.

So therefore, I have been doing this for the last 5 years when he has been so very ill. He has been ill a total of 7 years, but 5 years intensive illness, and taken nine times by emergency to the University Hospital. They have a little joke going, and they say, "Don, you are quite a guy."

As a matter of fact, they have a very strong interest in my husband because they say they have not seen anybody survive such severeness. His blood pressure is 244 over 160, which is beyond stroke level. And they are studying him because they feel he has such a strong biofeed. Are you acquainted at all with what biofeedback is?

Senator HEINZ. A little; I know of it, but I have never tried it.

Mrs. YELINECK. Well, I do not know how to track it. It just comes natural to my husband, apparently.

Senator HEINZ. And it works?

Mrs. YELINECK. Yes. And also, they have complimented me and allowed me to sleep in the room with my husband when he is critical. They have a bed alongside his bed, and he holds onto my hand, and they say I am giving him my strength that I have.

Senator HEINZ. Do you think you are?

Mrs. YELINECK. I am hoping that I am.

Senator HEINZ. Let me ask you one last question. If you think back 7 years ago or even further back, I guess, 8 years ago, when your husband first turned 65, became eligible for Medicare——

Mrs. YELINECK. Yes.

Senator HEINZ. Did you think that most of your health care needs and concerns would be taken care of by either Medicare or the Medigap insurance that I understand you had?

Mrs. YELINECK. Oh, yes, Senator, yes.

Senator HEINZ. And so you never anticipated that something like this would happen?

Mrs. YELINECK. One does not expect something like this. Do you expect anything like this?

Senator HEINZ. I do not mean in terms of the illnesses. I mean in terms of the bills, between your policy and the Federal Government Medicare Program, did you have any inkling that you were not well-protected?

Mrs. YELINECK. No, sir—especially after taking out the supplemental insurance policy. We thought we were very well-covered. Plus Don took out another supplement which would cover a nursing home. And he said, "God forbid we would ever have to use this." But we thought all right, we had better, we had just better.

Senator HEINZ. And why hasn't the nursing home supplement paid the bill at Clearview?

Mrs. YELINECK. First of all, Clearview is a Medicare-approved care center, which very few are, and my husband is in what they call the 24-hour skilled nursing care. And actually, he should be totally covered by Medicare because of needing 24-hour skilled nursing care. But their argument to me was that he has reached a plateau where he is not getting any better and he is not getting any worse. So he asked for a second opinion last Thursday, and they are going to convey him by patient's conveyance to University Hospital, where the four doctors who have been taking care of him for 7 years.

A cardiologist came in the last time, and he said, "Mrs. Yelineck, I am so sorry to tell you this. I have been a cardiologist here for 27 years. Medicare has overruled me and told me that I must send your husband home." He said, "He is likely to have a cardiac arrest tonight with his arrhythmia, his heart."

I thank the Lord he did not.

Senator HEINZ. Mrs. Yelineck, my time has expired.

Mrs. YELINECK. Oh, I am sorry.

Senator HEINZ. No, it is not your fault. The committee operates under rules of fairness that are appropriate, and I am sure my colleagues, Senator Pressler and Senator Burdick, will have other inquiries.

But I thank you. All I can say is I suspect you are not alone when it comes to people who, having a Medigap policy, having Medicare, wake up one day, maybe many years later, and find that their insurance policy covers them everyplace except that it has got a hole over the heart. It doesn't cover nursing home care. And that is where you have really been hit.

Mrs. YELINECK. Yes.

Chairman MELCHER. Senator Burdick?

Senator BURDICK. Thank you, Mr. Chairman.

Mrs. Yelineck, welcome to the committee. As I understand your situation, to recap a little bit, you have sold your home.

Mrs. YELINECK. Yes, sir.

Senator BURDICK. You have no income yourself?

Mrs. YELINECK. No, sir. Our income is our Social Security.

Senator BURDICK. Social Security. Outside Social Security, you and your husband have no income?

Mrs. YELINECK. No, sir.

Senator BURDICK. And how much Social Security do you get, together?

Mrs. YELINECK. You see, I worked for my husband, and wife working for husband, there is no deduction. I get $190 per month, and my husband gets $439.

Senator BURDICK. And that is your total income?

Mrs. YELINECK. No, sir, that is not my total income. Excuse me. I thought you were asking about Social Security. You see, I am getting confused now. No. We get $630. Our total income is $1,259 per month.

My husband broke this all down for you. Our rent expense is $395; our heat, $50; our electric, $40; our water, $15; our medical insurance is $120 per month; our household belongings are $30 per month; our cable TV, which is necessary because the building has it; our car insurance, maintenance, license and gas is $90 per month; our prescription drugs are $85 per month; travel to the University of Wisconsin back and forth with room and board is $50 per month; our food is only $150; miscellaneous, $25; and dentistry—my husband had the whole top of his mouth become ulcerated, and they had to do root canals, if you are acquainted with that—and we are paying that off at $124 per month—which is a total expense of $1,259.

My husband has figured out that the medical expenses alone are $370 per month—that is for Physicians Mutual, a supplement, prescription drugs, travel for medical in Madison at $50 per month, and the dentist at $124, which comes to $379 per month.

Senator BURDICK. Well, having given those details, they far exceed your income.

Mrs. YELINECK. Yes, they do, sir.

Senator BURDICK. What do you do about the difference?

Mrs. YELINECK. I have been borrowing money.

Senator BURDICK. Have you got people who will loan you money?

Mrs. YELINECK. Yes, yes.

Senator BURDICK. Relatives and friends?

Mrs. YELINECK. No. It is a banker.

Senator BURDICK. A banker who will loan you money?

Mrs. YELINECK. Yes—on character alone.

Senator BURDICK. Well, how do you expect to pay the loans back?

Mrs. YELINECK. I do not know. I do not know. Right now, I do not know.

Senator BURDICK. Well, getting back to what you have to break the fall a little bit on this, you have insurance and extended insurance, health insurance.

Mrs. YELINECK. Yes, sir.

Senator BURDICK. But that does not cover it, as you have just related here.

Mrs. YELINECK. No.

Senator BURDICK. Well, we are interested in situations like yours.

Mrs. YELINECK. I am not alone, Senator. I only wish I could have brought the people along who are our friends, our age, who are losing their homes the same way.

Senator BURDICK. That is why we are looking at catastrophic insurance. And it seems to me, from the statements you have made about your husband and yourself, that you are just about a candidate for that program.

Mrs. YELINECK. Oh, yes, I think we certainly are, yes.

Senator BURDICK. Well, thank you very much, and I hope the banker still looks friendly at you.

Mrs. YELINECK. Thank you, Senator.

Chairman MELCHER. Senator Pressler?

Senator PRESSLER. Well, thank you very much for being here. One area of interest that I have is, there are frequently ads advertising Medigap insurance on TV that are usually by some famous movie star.

Mrs. YELINECK. Yes, I am acquainted.

Senator PRESSLER. I am certainly not against that; I am all for private health insurance. But those ads gave me the impression that if you bought the Medigap insurance in addition to your Medicare, you were covered. Now, is that the impression you had?

Mrs. YELINECK. Oh, definitely, yes. And as I said, my husband being a former agent, he read the policy over and felt it was just a fine policy to cover us.

Senator PRESSLER. Well, then, how much of it covered you? How much of this extra Medigap? There are different names for this, some people call it extended insurance.

Mrs. YELINECK. Yes. This is called a supplemental.

Senator PRESSLER. Supplemental. That is what I see on TV in the mornings being advertised, isn't it?

Mrs. YELINECK. Yes.

Senator PRESSLER. What does that cover?

Mrs. YELINECK. If Medicare does not approve it—we did not learn this until after having the policy in effect for about 3 or 4 years—if Medicare does not approve it, then you pay.

Senator PRESSLER. For example, in your case, what Medicare didn't approve wasn't covered. Why not?

Mrs. YELINECK. There are many charges that doctors make that are over what Medicare feels that they should make. And one of the surgeons, who I will not name, who is considered one of the finest urologists, overcharged my husband terribly, and he was "spanked" to the tune of $83,000. Now, there was just a small little article in the Milwaukee Journal about this specific doctor.

But this is going on all the time, and not only that, Senator Pressler, when Don opened his own practice we had perhaps six or seven accounts that we kept of doctors, and when I would call their attention to how they collected from insurance companies and also from the patients themselves, and I would say, "Well, Doctor, you are collecting double here"—"Just turn your head the other way."

Senator PRESSLER. Well, I am a great believer in the private insurance system, but I am always eager to learn where it is not working. Later on, I hope we will have expert witnesses, and I can ask them questions. I think we should sort of build a chart here, or at least I will, as to what is covered and what is not covered, because I thought more was covered than apparently is.

Mrs. YELINECK. Oh, you would be very surprised, Senator, if you got into the situation.

Now, I have turned over all that documentary proof of what is covered and what is not covered, and Jim Michie has all that, and he will be sending that back to me. And it is about that thick.

Senator PRESSLER. Now, when your husband's illness began, did you understand what Medicare would cover? Was there ever an at-

tempt by hospital personnel or anyone else to explain to you what Medicare would and would not pay for? How did you learn what Medicare or Medigap would not cover? Was it by getting the bills, or did someone explain this?

Mrs. YELINECK. Exactly, exactly. Now, I have just been going the rounds with Clearview Care Center, and they said, "We have nothing to do with your supplemental insurance." They will not take "assignments" is the word that they use. They bill us, and it is up to us to see that that bill is paid.

However, I have had four different people who are acquainted with legal matters examine the policy, and they all come up with a different interpretation. So, as I mentioned before to Senator Melcher, I put in a call to Michael Egelson, who is the agent, to come to Clearview Care Center and explain this policy and why we are not being protected the way we thought when we purchased the policy. It is very ambiguous.

Senator PRESSLER. Thank you very much.

Mrs. YELINECK. You are very welcome.

Chairman MELCHER. Mrs. Yelineck, I do not want to have you state right now in public the name of the company, but we will ask you privately the name of the company, and we will help you in determining what the legal coverage of that policy is. We will establish that.

Mrs. YELINECK. Oh, you are making my heart dance now.

Chairman MELCHER. And might I say to everyone else who has insurance, we will likewise insist, no matter what the company is, in making sure that someone in your situation, has assistance from this committee staff establishing exactly what the coverage is.

Mrs. YELINECK. I certainly would appreciate that.

Chairman MELCHER. Well, we feel a grave responsibility on that. At the outset, I mentioned that the committee will want to establish exactly what Medicare covers and what it does not cover, and put it in an easily-understood form, pamphlet, booklet, what-have-you, and make sure that it is available to each and every Medicare beneficiary and prospective Medicare beneficiary, too. That is all of us.

Mrs. YELINECK. This is very necessary, Senator Melcher, very necessary.

I happen to be a bit younger than my husband, but many of our friends, husbands and wives, are of the same age. And it is very difficult to understand what you are going to benefit, very difficult. It has to be simplified—especially if you have been a patient and you are coming out of the hospital, it takes an awful long while for these wheels to get going the right way. The last thing in the world you want to start worrying about right away is wheels; you just want to recover—right?

Chairman MELCHER. Right, right. That is normal. That is part of our human system.

Senator Wilson has just joined us, and we welcome Pete to the committee. Do you have a statement you would like to make?

Senator WILSON. No thank you, Mr. Chairman.

Chairman MELCHER. Thank you.

Mrs. Yelineck, I take it you are a nurse?

Mrs. YELINECK. No. I started out in training, and I got kicked out for breaking the rules with my husband. It was a Catholic hospital, and the old nun was sitting there in the dark, and she caught me. And I did that three times, and three times I was caught.

Chairman MELCHER. Three times and you were out?

Mrs. YELINECK. Yes. [Laughter.]

Chairman MELCHER. And did you say your daughter accompanied you?

Mrs. YELINECK. Yes, she did, sir.

Chairman MELCHER. Would you identify your daughter, please?

Mrs. YELINECK. Loris, would you please stand up? This is Loris Ellis, and she is from Madison, WI. That is about an hour's drive from Beaver Dam.

Chairman MELCHER. Yes, I know where Beaver Dam is.

Mrs. YELINECK. Do you?

Chairman MELCHER. Yes, I do.

Mrs. YELINECK. Do you have some friends there?

Chairman MELCHER. No; I was at Camp McCoy during World War II. I am very familiar with the part of the country you come from, and very beautiful country, too.

Mrs. YELINECK. Oh, yes, it is. The deer are running all over like crazy now; we have got such a population of them.

Chairman MELCHER. Mrs. Yelineck, you mentioned prayer.

Mrs. YELINECK. Prayer, oh, yes.

Chairman MELCHER. You said you prayed coming in, and you mentioned it otherwise, too, in terms of the illnesses that have afflicted you and your husband.

Mrs. YELINECK. Yes.

Chairman MELCHER. Might I just say that this committee and this Congress are here to do more than just pray. We will pray along with you, but we expect to do more. I think your experience is truly an example of how catastrophic illness expenses affect an entire family. It affects you and your husband, and I daresay it affects your daughter, and I think you said you had other daughters, too.

Mrs. YELINECK. No. This is my only child I was blessed with. I have Rh-negative blood, and at that time, they did not know that it does not mix with positive. But I am so happy I have her.

Chairman MELCHER. Well, thank you both so much for coming. Your story is one that needs to be told, so that people not just in Congress, but the American public understand, that these circumstances do exist, and they should be alleviated.

Thank you very much.

Mrs. YELINECK. And I thank all you gentlemen so very much for what you are doing.

Chairman MELCHER. Our next witness is Mrs. Edith Rieger, from Alva, OK.

STATEMENT OF EDITH RIEGER, ALVA, OK

Chairman MELCHER. Mrs. Rieger, will you tell us in your own words what your circumstances are and the circumstances of your husband and your family?

Mrs. RIEGER. OK. About 7 years ago, he had to have two vascular surgeries, which I am sure you know what that is—well, he has had three, but one was several years ago, and then about 7 years ago, within 7 weeks, he had to have two vascular surgeries.

The last vascular surgery that he had, he had a pretty severe stroke on the operating table. Then about 6 weeks after that, he had to go back and have kidney surgery.

Well, his insurance paid all but about $2,500 of all three surgeries, and I have gotten that down to about $700 now. But there have been several months I have not been able to send the hospital any money. This is one hospital that has not been pressing me because they say they know that eventually, I will get it paid.

Well, I kept him home, oh, approximately 4 years after he had the vascular surgeries. I had to go to work because his Social Security at that time was approximately $425. And many a time, I would come home and find him lying on the floor—he had been there all day—one day I came home, and he had fallen in the bathroom, and he had blisters all over his legs where he had struggled trying to get up. One time, he had broken ribs when I came home. But I still worked and tried to keep him home.

Then I came one day and found him, and he could not talk to me; he could not even drink water. I called our family doctor, and he came right over. That is when he told me, "Mrs. Rieger, you cannot keep him home any longer." He was completely paralyzed, all but—well, he could not walk, and at that time he could not speak. He knew everything that was going on, and I told my doctor, "I cannot tell him he is going to a nursing home; you will have to do it." So he told him he would have to go to the convalescent home until he could take care of himself, which he knew he could never do.

But he was willing to go, and I guess I am fortunate in this. I have a wonderful nursing home that he is in, and he has never asked me to come home. In this nursing home, the ones that have their right mind and everything, they are all put in a wing separate from the others. So he does get out and watch television; they take him the wheelchair.

Since he has been in the nursing home, though, he has had two or three more strokes. Once in a while he can talk to you, but usually it is just a whisper, and you have to kind of guess at what he is saying.

The only thing that upsets him is he will get to crying sometimes, and I will ask him what is wrong. He says, "I do not like for you to be working as hard as you are."

And I tell him, "Well, you took care of me all these years. I will take care of you now."

But it is getting to the point where I do not know. Now his Social Security check is $498, which they will be taking some more—I will be having to pay the nursing home a little more, because they got a raise. He is supposed to have $25 per month.

They do allow five prescription drugs, but he only takes two that have to be written by the doctor. The others are medicine that you can buy over-the-counter. I have to pay for that, and I have to pay for his personal belongings and have his hair cut and things like that, which is more than the $25.

Therefore—I am supposed to take high blood pressure medicine and a heart pill four times a day—I have not been able to buy them. I broke a cartilage in my knee which the doctor says I am going to have to have fixed, but there is no way I can do that, either. My glasses were changed about 7 years ago, and my eye doctor is worrying me about that, but I just do not go and get it done.

I should be able to draw some Social Security myself. They let me have $200. I get it about 4 or 5 months out of the year, and then they cut it off. If they would take what my take-home pay is, I do not make near enough, but they count what you get before your taxes are taken out. So therefore, they cut my Social Security off.

Chairman MELCHER. How old are you?

Mrs. RIEGER. I will be 68 in May.

Chairman MELCHER. And your husband?

Mrs. RIEGER. My husband is 83.

Chairman MELCHER. He is 83. Where are you working?

Mrs. RIEGER. I am a cook at the VIP Supper Club in Alva, which as I said, I am doing the hardest work I ever did in my life.

Chairman MELCHER. How many hours a week?

Mrs. RIEGER. Well, right now we are short of help, so I go to work at 6:30 in the morning and get off at 3 p.m., 6 days a week.

Chairman MELCHER. Six-thirty to three?

Mrs. RIEGER. Yes.

Chairman MELCHER. What is your income per week, gross?

Mrs. RIEGER. It averages out to $600 a month.

Chairman MELCHER. One hundred fifty dollars a week, then?

Mrs. RIEGER. Yes.

Chairman MELCHER. And you are working 6 days a week.

Mrs. RIEGER. Six days a week right now. My boss does not like for me to have to work over 5 days a week, but as I said, we are short of help now, and until he can get something to work out, I have to work 6 days a week.

Chairman MELCHER. And is your husband's Social Security $498 per month?

Mrs. RIEGER. Yes. And if it would come to where I would have to quit, they tell me all I could draw would be half of his—and who could live on that? You could not do it.

Chairman MELCHER. You are putting off your own health care needs in order to work?

Mrs. RIEGER. I sure am, in order to work. My druggist got after me the other day. I thought I owed them about $1,000, but my drugstore bill right now that I have not been able to pay is $1,300.

Chairman MELCHER. Now, are those drugs for yourself?

Mrs. RIEGER. For myself and my husband.

Chairman MELCHER. For both of you.

Mrs. RIEGER. Yes, because up until just recently, I had to pay all of his drugstore bills. I had to buy all of his medicine. It has just been in about the last 3 months that they have picked up any of the prescription medicine for him.

Chairman MELCHER. That is while he is in the nursing home, after he went to the nursing home?

Mrs. RIEGER. Yes.

Chairman MELCHER. They are still not picking it all up?

Mrs. RIEGER. No.

Chairman MELCHER. So a portion of your husband's prescriptions——

Mrs. RIEGER. I am having to pay myself.

Chairman MELCHER. What does that run per month, including your own?

Mrs. RIEGER. Well, if I bought mine and his both, I would be paying around $75 month. Right now, last month, I paid—his runs different—but the last month, I picked up $32 of his that was not.

Chairman MELCHER. Now, I want to get this straight. He has Social Security income.

Mrs. RIEGER. Yes.

Chairman MELCHER. He is eligible to be in this nursing home and pay $25 per month?

Mrs. RIEGER. Twenty-five dollars is what is left out of his Social Security that I can use to pay.

Chairman MELCHER. All the $498 except $25?

Mrs. RIEGER. Yes—goes to the nursing home.

Chairman MELCHER. I see. So you are faced with paying the prescriptions for yourself and him and taking care of whatever your medical needs are, and waiting for the golden day when you are financially able to have the knee surgery——

Mrs. RIEGER. Yes.

Chairman MELCHER. And what is your other medication for?

Mrs. RIEGER. High blood pressure and a heart condition. I have not taken any heart pills for quite a long time, because they are the most expensive.

Chairman MELCHER. Have you been able to save any money, or did you have any savings?

Mrs. RIEGER. The first 6 months that he was in the nursing home, it took everything we had.

Chairman MELCHER. All of your savings?

Mrs. RIEGER. Yes.

Chairman MELCHER. And so you still have to pay $700 of hospital charges that go back 7 years?

Mrs. RIEGER. Yes, and then on top of that, I owe our former doctor, who now has retired, I owe him $1,500—but Dr. Simon said, "Well, I know you will pay it someday, Edith, so I am not going to press you for it." But I am just one who does not want bills hanging.

Chairman MELCHER. So $1,500 to him, $700 to the hospital, and $1,300 to the drugstore.

Mrs. RIEGER. Yes. And I have been paying the Alva Hospital. I owe them some on his last trip to the hospital. I have got that down to $43, though, which I will be able to take care of.

And on top of that, he had a Medicare supplement, but I had to drop it because I could not pay it.

Chairman MELCHER. In other words, you exhausted what you had set aside, and in order even to cope with the past bills that you are paying off, you are working 50 hours a week cooking at the supper club and putting off your own health care needs.

Mrs. RIEGER. Yes.

Chairman MELCHER. Well, I am pleased that you have a very confident outlook about you. Those are not the best of circumstances.

Mrs. RIEGER. I will struggle and pay it some way, some time, but there are still days when I go home and—my day consists of getting up at 6:30, going to work, coming home, maybe resting an hour, going to the nursing home and spending the rest of the evening, come home, and get up and do the same thing all over.

Chairman MELCHER. That is a tough life.

Thank you, Mrs. Rieger.

Senator Heinz.

Senator HEINZ. Mr. Chairman, thank you.

Mrs. Rieger, you mentioned that you had a Medigap policy for something like 18 years; is that right?

Mrs. RIEGER. Yes.

Senator HEINZ. But you had no idea that it would not cover the kinds of costs and problems you have experienced?

Mrs. RIEGER. Well, now, I feel that his Medicare policy covered pretty well, because those vascular surgeries are not cheap, and I felt it did pretty good. If he had not had to go to the nursing home, we could have had that all paid, but——

Senator HEINZ. Did you think that the nursing home costs were going to be covered?

Mrs. RIEGER. Oh, no. I knew that would not happen.

Senator HEINZ. So you did not feel you got blind-sided here?

Mrs. RIEGER. No, not on that.

Senator HEINZ. Is there anything that, if you look back 5 or 10 years, you would have done differently, knowing the kinds of problems you were going to encounter?

Mrs. RIEGER. Well, I do not know of anything I could have done differently, really.

Senator HEINZ. Are you at the point now where your bills are so big that you do not know how you are going to pay them?

Mrs. RIEGER. From month to month now, medicine and things are going up so high that, yes, I do wonder, because until I make a house payment and insurance—like house insurance, which you have to have; car insurance, which you have to have—no, I do not know, because right now I owe the man who carries my car insurance $120. He said, "You cannot run around here without car insurance. I am sending it in for you."

I said, "I do not know when I can pay you."

He said, "You will pay me. I know that."

But I do not like to have people do that for me.

Senator HEINZ. You mentioned that you have postponed having the cartilage surgery on your knee because you cannot afford it.

Mrs. RIEGER. Yes. And the doctor told me, "I can put shots in there two more times, and that is all you can have."

Senator HEINZ. You also indicated you were on blood pressure medication.

Mrs. RIEGER. Yes.

Senator HEINZ. Do you take that every day, or are there times when you do not take it because you cannot afford it?

Mrs. RIEGER. I have not had my blood pressure filled for about a month, now.

Senator HEINZ. So you are not taking your medication?

Mrs. RIEGER. No. The druggist says, "Well, you can charge it." I said, "Yes, but you are charging me interest on that every month, and the interest amounts to more than sometimes what I can pay on the bill."

Senator HEINZ. So that's the reason you are not taking your medication?

Mrs. RIEGER. Because I do not have the money, and I just do not feel I can afford to charge, because I do not want to run up any more bills.

Senator HEINZ. So you are putting off a lot of needed medical care because you cannot afford it.

Mrs. RIEGER. Yes.

Senator HEINZ. Do you know of any other people who are doing the same?

Mrs. RIEGER. Yes, I do. I could have brought a lot of names along with me of people who are in the same boat I am.

Senator HEINZ. What should all of us here in Congress or for that matter, in the administration, learn from this, and in your opinion as you look not just at yourself but these other people, what is the solution? Should individuals be doing more for themselves? Should families be doing more? Should employers be doing more or should the Government be doing more? Where does the responsibility lie, and who should accept that responsibility?

Mrs. RIEGER. I really do not know what to say. I mean, I do not know on that. The thing about it that disturbs me is that my husband had had this Medicare supplement. He worked at the college for 17 years. He had this insurance then, which the college covered; then, when he left the college, he could put it into a Medicare supplement. Well, it kept going up; each month, it would raise. When it got up to $60, I could not pay it so I had to drop it.

Senator HEINZ. So you dropped that. When did you drop that?

Mrs. RIEGER. About a year ago.

Senator HEINZ. Was that before or after you started getting these additional bills?

Mrs. RIEGER. Oh, well, I had bills then, yes.

Senator HEINZ. And some of them were being paid by the supplement?

Mrs. RIEGER. Well, if he went to the hospital, yes. Now, the nursing home he is in has several registered nurses. It is a family-run nursing home, and we are very fortunate to have such a good nursing home in Alva. I said to my doctor, "I do not know what I would do if he would have to go to the hospital."

He said, "Well, it is going to have to be something drastic—very bad—if I send him to the hospital, because he will get better care right here than at the hospital, and they can handle almost everything."

Senator HEINZ. One last question, because I know Senator Pressler and others have questions. Hypothetically, if either the private insurance industry or the government designed a true catastrophic and long-term illness policy that really did the job, that did not inflict on you or on Mrs. Yelineck the kinds of sacrifices that you have described, and let us say—and I am pulling a number right out of the air—but let us say it costs a fair amount of money a

month. Let us assume it costs $100 a month $1,200 a year—and you started subscribing to that policy at age 45. As you look back, would have been worth it or not to have paid that kind of money for real security?

Mrs. RIEGER. Well, I think it would have been.

Senator HEINZ. All right. Thank you.

Chairman MELCHER. Senator Pressler.

Senator PRESSLER. Well, first of all, I want to thank you very much for being here. I do want to say something in general first, to sort of summarize this hearing as I see it.

We see today people—hard-working people—who do not expect handouts, who are in trouble. These appear to be white, middle-class people. We cannot say it is a result of racial discrimination or misfortune. They seem to represent typical American citizens, and they are in great financial hardship. We cannot say that they are lazy, that indeed someone who is 68 and still working as a cook in a restaurant is not making a great contribution.

I guess there are two lines of questions that I have. What should you have done in terms of buying insurance? Has anyone told you, were you to go back 20 years and going to buy insurance, what should you have bought, what should you have done to prevent this, other than being very wealthy?

Mrs. RIEGER. You know, 20 years ago, I do not suppose I ever even thought that I would be on Medicare. I do not know. I think we should have probably bought something. We did have insurance, but like I say, when my husband got sick, it was just so expensive that I just could not keep it.

Senator PRESSLER. Yes, you could not buy it then.

Mrs. RIEGER. I have never had a Medicare supplemental policy, myself.

Senator PRESSLER. The point I am asking is a technical one, and I will ask it of staff later, and I do want staff to focus in on this. I would like to know as a Senator, if there had been a way that these people could have managed their resources to buy insurance so this could have been avoided. I think the answer to that question is no; I do not think you could have bought insurance. Unless you are an expert on insurance, it is awfully hard to know what you have got. You can only find out when you try to collect it. I am not criticizing the insurance companies, because I know it is all written down, but the average person does not think about it and does not research it, or cannot.

For example, we recently had a burglary in our Capitol Hill house, and I have no idea what we can collect insurance on and what we cannot. We are just filling out the forms, but I must say I do not expect we are going to be able to collect very much. But even as a U.S. Senator, I have no idea what we are going to be able to collect. I guess I will find out maybe the hard way, but I will find out shortly.

That is analogous of the situation you are in, isn't it? You go along, and you have what everybody else has, apparently. You are working hard; and all of a sudden you find out that you haven't got what you thought.

I do want to see, on these witnesses this morning, I think we can use your cases to illustrate a point. I am going to have staff try to

tell me how you could have theoretically managed your resources so you would be covered today. I think the answer is that there is no way you could have done it.

Mrs. RIEGER. There is another thing I forgot about insurance. I took out two or three medical policies, and I took them to my family doctor to look over. And he said,

> Edith, I hate to tell you this, but with your high blood pressure, no matter what comes up, the insurance company is going to throw it right back, that it was due to your high blood pressure, and you are not going to get a thing.

Senator PRESSLER. I think that illustrates another point I was going to make. I know that Governor Lamb of Colorado has written a book saying we cannot provide everything to everybody, that we have to make choices. But I think the witnesses today are very good because they illustrate that they are not getting heart transplants or that sort of thing. They are getting what all of us would hope to get—normal treatment—and there is nothing extraordinary about what is happening to these sick men that would not happen to anybody. I think all of these people are in the category of people who would not even be in Governor Lamb's extreme decisions that he says have to be made.

So that it is a problem that this Committee has to face. We have to face up to it. A lot of Americans are in severe trouble, people working, as you are working at age 68—and I hope I will still be able to be working at age 68, even just indoor work like this, and no heavy lifting.

It is a severe problem, and we have got to address it. Now, Secretary Bowen has a plan that if people were to pay $5 or $10 extra a month, a lot of these things would be covered. Of course, I do not think all your cases would be covered. I would like to see staff also give a comparison.

Mr. Chairman, later can we get a little chart from staff that would show if Secretary Bowen's plan, and we will have him here Wednesday, if this were in effect, would these particular cases be covered? Would this case be covered? Would this lady be sitting here if Secretary Bowen's proposal were in effect? [1]

Could staff answer that, or could we maybe get that later? You are an expert, Mr. Chairman.

Chairman MELCHER. Well, I and Senator Kennedy introduced the bill to implement what we believe the Bowen proposal would do and what Dr. Bowen says it would do. It would not cover this circumstance in that long-term health care is not provided for.

Now, whether or not it would cover Mrs. Rieger's particular case in paying for the high blood pressure medication, I would hope it would, but we need to know what the Bowen proposal would actually do, because we hope to have it on the Senate Floor sometime this year, and we will have to know all the ins and outs of it. I am looking forward to Dr. Bowen's explanation about what his proposal will do when he testifies before the Committee on Wednesday.

Senator Wilson.

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[1] See transcript of January 28, 1987 joint hearing between the House Select Committee on Aging and the Senate Special Committee on Aging.

STATEMENT BY SENATOR PETE WILSON

Senator WILSON. Thank you, Mr. Chairman.

Mrs. Rieger, neither you nor Mrs. Yelineck are very good witnesses in one sense—neither of you ladies look your age. And I must say I think you have evoked the admiration of the members of this Committee for your courage.

Let me try to pick up on Senator Pressler's line of questioning. I am not quite clear from what you said—was your husband a member of any kind of a group health plan before he became incapacitated?

Mrs. RIEGER. He had a Medicare supplement is all.

Senator WILSON. But this was private insurance to supplement his Medicare coverage in connection with group coverage from his employment?

Mrs. RIEGER. Well, it was a group coverage when he worked at the college, but after he left the college, you could take it out on an individual basis.

Senator WILSON. To extend the coverage, he could continue to contribute.

Mrs. RIEGER. Yes. But they just kept going up on us, and when it got to $60, I could not pay it.

Senator WILSON. Sixty dollars——

Mrs. RIEGER. A month.

Senator WILSON. And I assume that you have had no similar kind of opportunity to participate in any kind of an employer/employee group plan?

Mrs. RIEGER. No, because I was one that I was not going to have to work, you know. I was not going to work unless I just wanted to. I mean, we were out on the farm, and yes, I worked out on the farm.

Senator WILSON. I understand.

Mrs. RIEGER. But like I told somebody, it was not near the hard work I am doing now. Even when I was milking cows, it was not as hard as what I am doing now.

Senator WILSON. I gather that notwithstanding the burdens that have been visited upon you and your husband, you still do not qualify for Medicaid.

Mrs. RIEGER. Well, now, is Medicaid what picks up from his Social Security?

Senator WILSON. Medicaid is available to a class that is described as "medically indigent"—those who are suffering such heavy medical costs—or I should say, those whose circumstances qualify them. It is low-income. And because your husband is not working, and because of your situation, I am not sure——

Mrs. RIEGER. Well, in the nursing home they pick up what his Social Security check does not cover, after 6 months, but now I had to take care of it. Well, that depleted everything.

Senator WILSON. Let me ask this question of staff, and I do not know whether they know. Are Mrs. Rieger's circumstances such that she is entitled to Medicaid coverage?

Mr. MCCONNELL. I think she gets Medicaid coverage——

Mrs. RIEGER. I think on my husband, that is probably what that is called.

Mr. MCCONNELL. Yes, but you have to pay a portion of it.

Mrs. RIEGER. Well, like I say, they take his Social Security check all but $25, and I am supposed to pay—well, like I say, they said they would pick up five prescriptions. Well, OK, he only takes two medicines that have to be prescribed by the doctor; the rest of it is over-the-counter, and I have to pay for that. They will not pay for that. And that amounts to more than what his prescription drugs do.

Senator WILSON. I am wondering, Mr. Chairman, what the interplay is.

Chairman MELCHER. Well, might I clarify this. I think this is one of the examples Americans are faced with. Clearly, the cost of what Mr. Rieger is receiving is covered by Medicaid. His Social Security defrays that up to $470-some a month. He has a total Social Security check of $498, which would only pay a portion of his nursing home care.

Mrs. Rieger does not get Medicaid because she has an income.

Mrs. RIEGER. No, I do not.

Senator WILSON. That was my point.

Chairman MELCHER. She can either go on welfare and get Medicaid, or she can continue to work as she wants to do, to pay off the previous bills.

Mrs. RIEGER. Yes, I will continue to work as long as I can.

Senator WILSON. That was the point of my line of questioning, Mr. Chairman. That is my surmise as well. And her problem, I gather, arises not from a single acute illness of her husband or herself, but the need for continuing care, long-term care, which is available under Medicaid to a degree.

Mrs. RIEGER. Now, the first 6 months he could have been covered had I divorced him. And that kind of got me when they told me that. I said you do not live with someone 40 years and divorce them just because they are sick. So therefore I spent what little I had accumulated.

I could state several cases there in Alva, though, where they have divorced to get the help.

Chairman MELCHER. To get the help immediately.

Mrs. RIEGER. Yes. But I would not do it.

Senator WILSON. It sounds, Mr. Chairman, as though Mrs. Rieger is in the position of really working a very tough schedule, working very hard, doing hard work and still being burdened with the extraordinary cost of these medications. My impression without knowing is that if she were not working, Medicaid might pay for most of the long-term care apart from the medications—that still, I do not think, would be included.

But that looks to me like an area that the committee ought to explore. It looks as though Medigap still has a gap in that regard.

Chairman MELCHER. Well, Mrs. Rieger, I think you demonstrate a rather admirable American quality of wanting to continue to work even though you are 67 going on 68, and even though you have high blood pressure and apparently a bad knee.

But let me say this. You and your husband must have worked all your lives, I take it, and made a contribution to the community and to the country.

Mrs. RIEGER. We have; we have worked hard. I have one daughter, and she is adopted, which I am very proud of, but she and her husband are having to struggle, too. They do help me some with my utility bills, which I could not pay if they did not. But I feel bad about taking that from them, due to the fact that they need it for themselves. But my son-in-law is a wonderful person, and he just wants to help me if he can.

Chairman MELCHER. Your doctor tells you no more injections in your knee—I assume those are cortisone-type, anti-inflammatory-type injections.

Mrs. RIEGER. I think so.

Chairman MELCHER. And after this, knee surgery will be required. Now, I think you ought to take your doctor's advice, because apparently, you want to continue making the contribution in a very meaningful way, and I do not know how you would——

Mrs. RIEGER. He says if I would go now, it will be less serious than if I wait a little while longer.

Chairman MELCHER. Second, this question of not taking high blood pressure medicine when your physician recommends it is also not a very wise practice. Now, I do not have to tell you that; you know that.

Mrs. RIEGER. Oh, I know that. I know what my blood pressure was the other night out at the nursing home—they take it regularly—and they just threw a fit.

Chairman MELCHER. I admire your comment about not following the practice of separating from your husband just so you could avoid some nursing home coverage in that first 6 months when he entered the nursing home.

Mrs. RIEGER. I just could not do that.

Chairman MELCHER. I especially admire it since my wife and I have been married just slightly over 40 years, and I will take your testimony home to her to show this loyalty. This loyalty is a great thing.

But in answer to Senator Heinz' question, let us get down to this. Now, you worked all your life, your husband worked all his life. Senator Heinz asked who you think ought to be taking care of this, and whose responsibility it is. I thought you kind of ducked that. You know, you have put in your time. You are a citizen of this country, and you can advise this Congress on what you think about this.

Shouldn't somebody step in here and take care of this?

Mrs. RIEGER. I think they should.

Chairman MELCHER. Well, who?

Mrs. RIEGER. I think the Government ought to.

Chairman MELCHER. Well, I thought maybe that was what you thought. As a case of last resort, the Government ought to pick up the tab, should they not?

Mrs. RIEGER. I do not want them to give me something that I do not deserve. But when you get older, and you are doing harder work than you have ever done—I feel like I have contributed a little bit to my country.

Chairman MELCHER. Yes, you have, yes, you have. And I assume your husband has, too; the way you described him, he certainly has.

Mrs. RIEGER. He was a very hard worker.

Chairman MELCHER. Now, what I am getting at is you forego doing what you are supposed to do for yourself. You are jeopardizing what it is going to take to keep you up and around and capable of a decent life. So I think you are between a rock and hard place; your situation is between a rock and a hard place, and you should not be there. There ought to be somebody picking up this tab after you are of a certain age. And that is what this Committee is about, too. We think there should be somebody.

Mrs. RIEGER. Well, thank you.

Chairman MELCHER. And if it needs to be the Government, if that is the last resort, then I think it should be. And it is a question then how high a priority it is. How high a priority is it to take care of situations like this.

Mrs. RIEGER. Like I said, I do not want them to give me money just to go out here and have a party on. I would just like to be able to pay my honest debts so I can face people.

Chairman MELCHER. Thank you very much for your testimony, Mrs. Rieger. I entirely agree with you. I hope you are able to continue to work at that supper club as long as you want to and feel like it, but I do not know. I think it is hard work, and I know what you are talking about when you say it is harder work than milking those cows or working on the farm; of course it is.

Mrs. RIEGER. It is. I can stop milking a cow, but when somebody wants something to eat, I cannot stop.

Chairman MELCHER. Yes, you have got to get those orders out right now.

Mrs. RIEGER. Right.

Chairman MELCHER. Thank you very much.

Mrs. RIEGER. Thank you.

Chairman MELCHER. Our next witness is Mrs. Helen Fish, of Newport, MI.

Mrs. Fish.

STATEMENT OF HELEN FISH, NEWPORT, MI

Mrs. FISH. Hello to all of you.

Chairman MELCHER. Mrs. Fish, would you describe in your own words what your family situation is presently?

Mrs. FISH. I am here in behalf of my mother.

Chairman MELCHER. I think you ought to move those microphones a little bit closer to you.

Mrs. FISH. OK. I probably would not need these microphones because I have a real, good, loud Hungarian voice.

I am here in behalf of my mother, who is 97 years old. She has lived with me now for about 7½ years. When my mother came to live with me, she was in fairly good health and was able to get out and live a fairly normal life, although she had had several episodes of CVAs, which are small strokes, which left her with partial paralysis at various times.

So that when she came to live with me, as I said, she was financially all right and physically fairly good. She also has a severe heart condition.

Four years ago this August was when our problems really started. She lost her right leg through amputation due to poor circulation. She had three major surgeries on her leg alone to try to preserve the leg, but it was useless. So she lost her leg and then became quite a care.

So I had to resort to hiring part-time nurses' aides. In our area of Michigan, the nurses' aides' rates go between $5.60 and $7.10 an hour. So out of her savings, of which she had approximately $35,000, obtained when my Daddy sold a little house that he had built. Her money started to diminish, and in just nurses' aides at 4 hours a day, 7 days a week, and then I had to pay a part-time nurse for $7.10 an hour. That amounted to over $10,000 a year, just in nurses' aide fees, which help is not sufficient to take care of an elderly person for 4 hours a day. At least 8 hours would alleviate the person taking care of her and give a little bit of respite from the strain.

I have the records here, and I have every one itemized. I have seven manila envelopes full of receipts. For everything that is spent on this little lady, every cent is written down.

So our problems really started in June 1983. Between June 1983 and October 1983, we spent $2,418. This is for medical supplies, for doctors, anesthesiologists, pathologists, her home care, medical equipment—the bed and so on all have to be rented.

Between October 1983 through December 1983, we spent a total of $3,666. This is the same. And inbetween here, I had three hospital stays and had to hire the nurse for 24 hours around-the-clock. Between December 1983 and January 1984, we spent $2,536—there is additional; I did not add the cents to all of these; I just took the amounts, like $160 and so forth, so it would be a little bit more.

Between January 1984 through March 1984, we spent $3,652. Between March 1984 and May 1984, we spent $1,838. Now, many of these are for the hospitals stays, and this is over and above what Medicare paid.

Between May 1984 and July 1984, $2,820. Between July 1984 and September 1984, $2,348. Between September and November of 1984, $2,600. Between December 1984 and March 1985, $2,230.

Then she had to go to the nursing home for 2½ months, which cost us $5,500 in the nursing home. This is all out of her savings. This was with no help whatsoever from Medicare or any other source.

Between March 1985 and July 1985, $5,971. Between July 4, 1985 and October 1985, $2,328. I will go fast here. Between October 1985 and January 1986, $2,222. Between January 1986 and April 1986, we spent $1,780. Between April 1986 through June 31, we spent a total of $1,863. We are coming up to 1986 now.

Between July 1986 and October 1986, $1,700. Between October 1986 through December 1986, we spent a total of $1,885. And then, over into January, which already we have spent $500 in 1987 so far, mostly all for nursing care. And where the largest problem is is in these Medicare patients. I guess I failed to say my father took out no other insurance, and this is why she has these tremendous amounts, because all she has is Medicare.

While in the hospital in Toledo, each time she went on her four or five hospital stays, she was in intensive care, which the beds run

approximately $700 to $800 a day. And we were not told at the time that she had used up all her hospital days, which I was not that fully acquainted with Medicare, and so the days that she was not entitled to, she had to pay for those days in her hospital stay.

So up to date, from 1983, she has spent $41,000 all-told.

Chairman MELCHER. Forty-one thousand dollars—of her own money?

Mrs. FISH. Of her own money.

Chairman MELCHER. Medicare paid most of it?

Mrs. FISH. This is up and above what Medicare paid. The doctor bills range in price from $1 to $1,900 as each doctor sent his bills, which is something that should be controlled, in my estimation.

Chairman MELCHER. You said your mother was 97 years old right now.

Mrs. FISH. Right now, yes.

Chairman MELCHER. So 4 years ago, she was 93.

Mrs. FISH. Yes.

Chairman MELCHER. And she had $40,000 cash?

Mrs. FISH. Seven years ago she had approximately that amount, from the sale of their home. That is when my Daddy left, and we sold her home.

Chairman MELCHER. How much more has she got?

Mrs. FISH. That is what I am here for. At the present time she has $4,000 and $4,000 for her burial expenses. When one of the ladies from social services applied for mother's Medicaid, she was not eligible, because she does get $440 in Social Security, which pays for 2 weeks of part-time nursing care. I myself am a heart patient, and I take care of her exclusively myself when I do not have a nurse's aide for 4 hours and sometimes up to 5 or 6 hours a day, occasionally.

Medicaid wanted me to get rid of that money, and then she could go on Medicaid. And I asked, "What will we do for funeral expenses?" and they did not care. The fact was that she still had that much money in her possession, which the $4,000 at $800 per month would be gone in approximately 3 or 4 months. To have available funds for good home care and TLC is what I'm mostly advocating for people like my mother—we do not see too many little 97-year-old ladies running around the streets. And this lady is one of the most alert people. I have a picture you gentlemen can pass around, and you will not believe this little lady is 97 years old. She is alert, and she was given up three times. They asked us if we wanted her to be a "no code," which means no resuscitative measures, and we said to do all they could for her, and it was worth it. She is 97 and still her mind is usually better than mine; a very alert "young" lady of 97 years old.

My request is that mostly in our area of Michigan, what we need is home care services; just asking for part-time respite hours or dollars to help the family, and the Government, as we say, would still be saving tremendous amounts of money. It would still put people to work. There are nurses' aides all over, desiring work, and no place for them to work. If some formula or help would come in just getting people like myself part-time assistance, it would mean a lot.

In the nursing home, she had to pay all that herself. She was not eligible for any assistance because she can feed herself, although

she has only 50 percent vision in one eye and the other eye is totally blind, and we can never leave her alone. In one of her major surgeries, she slipped off the edge of the bed, and hit the leg that was amputated, she broke the bone from the knee to the hip in half, which had to be removed. This was a major surgery that she was there for at great and enormous cost.

So what my request is is for help in home care nursing, because the nursing homes in our area are consistently full. When I went for major shoulder surgery 3 months ago, there was not a bed to be had in a nursing home in Monroe, so we kept her at home, and I paid a nurse's aide around-the-clock, 24 hours.

Chairman MELCHER. Over the weekend, I just came from visiting two of my aunts, one of whom is 93 and one is 94. Both are very alert, both are, in relative terms, very active, and are out and around. They do not drive a car anymore, but that is about the only thing they refrain from doing.

Now, tell me about your mother. This all started at 93?

Mrs. FISH. Well, her major problem was through the amputation of her leg, and she had several strokes and was incapacitated for a couple weeks each time, but then improved.

Chairman MELCHER. I understand. But was she up and around?

Mrs. FISH. Yes, definitely, definitely, yes. She went with me everywhere I went; she was able to go.

Chairman MELCHER. Was she able to read at that time?

Mrs. FISH. Partly, yes. The eye has deteriorated considerably in the last 3 years.

Chairman MELCHER. Was she living with you then?

Mrs. FISH. She has been with me for 7 years, since the death of my father.

Chairman MELCHER. All right. So she has been with you since she was 90 years old.

Mrs. FISH. Yes.

Chairman MELCHER. And she has been an active person up until the amputation?

Mrs. FISH. It will be 4 years, yes, up until almost 4 years ago.

Chairman MELCHER. Does she vote?

Mrs. FISH. I do not think so. I do not remember taking her.

Chairman MELCHER. That is the only thing she has given up—all right. Now, at 93 years of age, with 40,000-some-odd dollars in cash, she should have been quite secure, along with Medicare.

Mrs. FISH. She would have been, yes. My father did not believe in hospitalization, and foreign people do not let their children tell them what to do. Although we tried very hard to take out hospitalization for them, he refused. And this is where, like you said, I really would push having people understand that Medicare does not pay everything; to start younger in life. I would have the reporters writing consistently about it, urging people to realize this—which my father apparently thought—he died at age 93 and had been hospitalized only three times in all of his lifetime, at the age of 93, that was quite a record.

Chairman MELCHER. You are absolutely right on that, that people should understand very definitely what Medicare will pay for.

Mrs. FISH. Right. Even when my mother went to the hospital, and these were all major surgeries that she had, I did not myself realize that Medicare did not cover all these extras, like the doctor bills, which sometimes she gets bills from the associates and from the doctors. There will be five doctors in one group, and each one sends a bill. I have the proof for that, which is devastating to the patient, having to pay all these extra doctors and cardiologists and whatever.

In fact, she received a bill the day before I came, still for lab work which they did 10 months ago.

Chairman MELCHER. Your statement just a moment ago, recommending that there be some way of taking care of the patient at home with some assistance in home health care——

Mrs. FISH. Yes. That is all so many of us ask for, is just some assistance.

Chairman MELCHER. Some assistance, because after all if you have 16 hours out of the day where you are doing it all, the 8 hours that can be provided in home health care by a nurse's aide would make it possible to continue on with the type of care that is best for your mother.

Mrs. FISH. Right.

Chairman MELCHER. All right. I want to confess that the Bowen bill that Senator Kennedy and I introduced into Congress a couple of weeks ago does not cover that, and it is another shortcoming of the bill. So I think the Bowen proposal is a good starting point, but I would not want anybody to draw the conclusion that somehow it took care of some of the major difficulties that are catastrophic. I just wanted to mention that to you. But before we get done, I hope that Congress does enact a type of catastrophic that does pick up what is needed in home health care assistance for patients and also when it becomes one of the better solutions for that particular patient, in circumstances as a nursing home, that it picks that up, too, because those are the two major areas where the testimony we have received today tells us simply are not covered.

Mrs. FISH. To me it would be profitable, as I said, for the Government, in paying a much less amount for the patient to stay in the home. I understand—I have worked in a nursing home——

Chairman MELCHER. Oh, yes, by far the best.

Mrs. FISH. Right. I understand that there are patients who absolutely cannot be taken care of at home, like my mother when she first came home, it took two of us to handle a little 93-year-old lady with one leg. It is very, very difficult.

Chairman MELCHER. Senator Heinz?

Senator HEINZ. Mrs. Fish, obviously, you have recounted the kinds of financial difficulties that you have had and the need for some assistance to defray some of those. But beyond the financial difficulties, aren't there many others in terms of rendering the kind of care—does it not put strains on you—or are you able to handle it pretty easily?

Mrs. FISH. Can I handle the strain easily?

Senator HEINZ. Yes. Is it a strain on you emotionally?

Mrs. FISH. Yes, yes. I do have a heart condition, which does not help that much. I am on heart medication.

Senator HEINZ. So it is both a physical and emotional strain on you.

Mrs. FISH. Yes, yes.

Senator HEINZ. If you could afford it—and we recognize you cannot—would you under any circumstances place your mother in a nursing home?

Mrs. FISH. Well, she was not eligible to go to the nursing home without us footing the whole bill.

Senator HEINZ. I understand that. I am just asking, though, if you had the money——

Mrs. FISH. I would not want to. We are trying to hold out for 100, which is 3 more years, and she probably will make it.

Senator HEINZ. So given a choice, you would still rather keep your mother at home.

Mrs. FISH. With help, yes, yes.

Senator HEINZ. Rather than have her in a nursing home?

Mrs. FISH. Definitely, yes. Foreign people are a little funny that way, with their families.

Senator HEINZ. Do you know why your mother has not become eligible for Medicaid?

Mrs. FISH. Because as I quoted before, she has the $4,000 and then her burial expenses, which are intact and not to be touched.

Senator HEINZ. Have you ever been tempted to try and do something about that?

Mrs. FISH. Do you mean, getting rid of her money?

Senator HEINZ. Yes.

Mrs. FISH. Well, it would not take long by keeping a nurse's aide, which is $800 a month; $800 from $4,000 per month, it would use it up in a few months.

Senator HEINZ. It would take about 5 months, right?

Mrs. FISH. Right, right.

Senator HEINZ. Why have you elected not to do that?

Mrs. FISH. Not to do what?

Senator HEINZ. To spend the money on a nurse's aide.

Mrs. FISH. Well, I think it is the idea of going on Medicaid—perhaps. I do not know what all is involved with that. I did not check any further. As soon as they saw her record, they sent a letter of dismissal that she was not eligible at all for Medicaid.

Senator HEINZ. But you did not feel that you wanted to pursue that any further?

Mrs. FISH. No, no.

Senator HEINZ. Why? If I told you that there is this program called Medicaid; that it is run and paid for partly by the States, partly by the Federal Government, and under certain circumstances, it will take care of your costs if you do not have any money—why would you shy away from learning more about it?

Mrs. FISH. What would happen if this little lady would die, would pass away? Who would pay the burial charges? That is another question I am asking. They wanted all that money to be rid of for her to go on Medicaid.

Senator HEINZ. So you were nervous about what would happen to your mother if she passed away and she was on Medicaid?

Mrs. FISH. Yes, or if something happened to me—I would not know what would happen to her.

Senator HEINZ. It sounds to me, and I picked it up from our other witnesses, Mrs. Yelineck and Mrs. Rieger, like there is kind of a nervousness about finding out about Medicaid. Is that because Medicaid has some kind of a bad reputation?

Mrs. FISH. I do not think so, necessarily, no. I do not think so.

Chairman MELCHER. Would you yield, Senator Heinz?

Senator HEINZ. Yes, I would be happy to yield, Mr. Chairman.

Chairman MELCHER. Mrs. Fish, isn't it because you have to deplete all your money?

Mrs. FISH. Do you mean with my mother?

Chairman MELCHER. Yes.

Mrs. FISH. Yes, I think so. That is the underlying reason.

Chairman MELCHER. Nobody wants to be flat broke.

Mrs. FISH. I believe that is the reason. I think you have expressed it explicitly.

Senator HEINZ. Well, you said as much earlier. I am just trying to see if there are any other reasons there. That may be the central one, Mr. Chairman. People who have been proud and independent and self-sufficient all their lives may not themselves or in behalf of their parent want to see their parent put in a status which we call pauperized, penniless, absolutely destitute, poor. Those are pretty awful words. And that is what is involved, fundamentally, before you can become eligible for Medicaid. And if there is anything that most people fight like heck, having fought that way for a lifetime, to avoid, it is becoming dependent and losing their independence.

So I think you put your finger on it. I was just interested as to whether there might be any other problems out there.

Mrs. Fish, I thank you very much.

Mrs. FISH. The nursing care people that I did hire for my mother did have some assistance from the Government, but this is what they were pushing for at the forum. This is where I started, at a small forum in Monroe, MI, with some of the gentlemen from Lansing. They do have some Government assistance through the home nursing care. But I was only allowed 9 hours a week is what they paid for, and then I had to pay the rest of the 4 days myself. But they did give you 100 hours a year, which is not very much to help out with a patient.

Senator HEINZ. But that was available to you, 100 hours a year?

Mrs. FISH. It ran out. That ran out. And sometimes they can only give you 3 hours. It is whatever the fund has accumulated.

Senator HEINZ. But as you say, 100 hours a year is not much.

Mrs. FISH. One hundred hours a year. Only 9 hours a week is what they give. Maybe I misquoted. Nine hours a week is all they could give me.

Senator HEINZ. Thank you.

Chairman MELCHER. Senator Pressler?

Senator PRESSLER. Thank you very much, and thank you for being here.

I have made notes on what I see sociologically we are experiencing here today. We are not hearing from the very poor, the extremely poor. We are hearing from middle-class America. I might say that I think the selection of the witnesses has been very good. These are middle-class people. I know in our universities, when sociologists write, they like to write about the very poor or the very

rich. Indeed, in the academic community and elsewhere, the middle-classes are almost left out. In some cases, they are not thought to be a challenging subject for study.

But what we see here are middle-class Americans in trouble. We see no fraud. We are not talking about any fraud. We find nobody who really wants a handout. We are finding working people, no question about their honesty. Most of the witnesses here have been women taking care of men, although this particular witness is taking care of a woman. But, I can assure you there are some men taking care of women from my activities in the Alzheimer's group, and the people have had no warning of what was to come, and they are almost penalized for having made some savings or owning some property or trying to hang onto a house or some little bit of property. They are in a category that they would almost be better off if they were impoverished.

So I think we have a very special set of problems that are presented here this morning. I want to compliment staff on their selection of witnesses. I am one who does not believe in Government action except where it is extremely necessary. But here, I see people who are trying everything, who have done everything they can do, and yet they are in great difficulty. I commend these witnesses.

But do you ever get a feeling—if I may address this to you—do you ever get a feeling that you would be better off in this current set of circumstances if you were impoverished; you could get aid easier, could you not?

Mrs. FISH. Yes.

Senator PRESSLER. I think that is very significant. So once again, we are sort of penalizing those people who have some savings, who have a job, who try to pay their bills and find that it is impossible. It may not be a story that will make for great editorials, it is not a story that will make for great adjectives. But it is a real story of what a lot of middle-class America is experiencing, is that not correct? The people you know who are in similar circumstances, are they people who have worked hard and have some savings, own a house or a small business, or something of that sort?

Mrs. FISH. Right, yes.

Senator PRESSLER. I think that is a very significant thing. I hope as we go forward with our hearings on catastrophic illness expenses that we keep that in mind, because I think this is a very significant hearing from that point of view. I again want to compliment staff for the choice of witnesses because I think they illustrate very strongly a problem that is going to the roots of—not impoverished America; there is not racial prejudice here—it is reaching to the very roots of middle-class America. If you were very wealthy, you would probably be all right for a period of time, at least.

I think your testimony illustrates what I have been talking about. I have no specific questions. I thank you for your testimony.

I am going to have staff again tell me, if we had had Secretary Bowen's plan in place, would that have made a big difference in your case? Or, if you had bought more Medigap insurance would that have made a big difference?

Was there any way that, in your own mind, if you went back 20 years, you could have planned for this, or bought insurance, or done something?

Mrs. FISH. No. This is why I say people should be educated to this, to start——

Senator PRESSLER. They should be educated to it?

Mrs. FISH. Yes, because people do not think of it.

Senator PRESSLER. But what could you have done if you were educated or thought about it?

Mrs. FISH. I would have provided for this in the future—is this what you are asking? I did not hear you.

Senator PRESSLER. Yes.

Mrs. FISH. Definitely, yes.

Senator PRESSLER. What kind of insurance could you have bought to cover this?

Mrs. FISH. What kind of insurance—I do not understand your question.

Senator PRESSLER. What kind of insurance would you have bought, or how would you have provided for this?

Mrs. FISH. Do you mean like hospitalization?

Senator PRESSLER. Could you have purchased that?

Mrs. FISH. Yes. I had to purchase mine after I retired. I myself carry my own health insurance.

Senator PRESSLER. But if you had bought that 20 years ago, you could have bought it at a lower rate, and——

Mrs. FISH. Well, at work I was covered. So people do not think of this a lot of times, you know, because you are covered with a lot of hospitalization in your job. After I retired, then I had to pick up my own, and a lot of people perhaps do not do that.

Senator PRESSLER. But you did do that?

Mrs. FISH. Yes, yes. Well, when I was at work, I was fully covered with hospitalization, and I did not have to pay anything. After I retired, that is cut off right then, and then you have to pick up your own hospitalization. But my father, for years and years and years, he did not work, and he was not covered with any kind of insurance, ever. Even before he was working, they did not have it at that time.

Senator PRESSLER. OK. But I think if we dig into it, we would find that even if you had bought some of this insurance, or your mother had——

Mrs. FISH. I tried to get insurance for her, but she was past 87, so there was no insurance company where I could get anything for her at the time when she came to live with me.

Senator PRESSLER. Well, then, maybe we need a public information program—I do not know how we would do it; it is a complicated thing. It seems as though there is almost no way for some people to escape your situation without the Government having some kind of catastrophic insurance.

Thank you, Mr. Chairman.

Chairman MELCHER. Senator Wilson.

Senator WILSON. Thank you, Mr. Chairman.

I am not going to ask any questions of Mrs. Fish. I think she and the other witnesses have been quite eloquent. One persistent theme in the testimony of all of them—one that perhaps came out most

pointedly in the comment from Mrs. Rieger that when the private supplemental coverage reached the premium of $60 a month, it was no longer affordable—resonates in the testimony that we can expect from the industry, that they think that more and more people are not insured for supplemental coverage because of its cost, not because of its availability. I think that is a truism.

And Senator Pressler in his questions to Mrs. Fish as to what she might have done—my impression is that in the last 5 years, although the industry is certainly much older than this, but in the past 5 years there has been a virtual explosion of private coverage offered in things like the Sunday supplement to a newspaper. My impression, too, is that they run the gamut from some that are very good to some that probably are not worth the premium.

I think the real question is the one that has been focused on in Mr. Shapland's written testimony, and that is, how do you make it affordable. So I would say that I think that Senator Pressler is correct in commending the staff and the Chairman in setting the hearing and in selecting the witnesses. I think these three ladies have given us a very sharp focus on the problem of perhaps the majority of Americans who have worked hard all their lives, tried to save, tried to be independent, only to come to that time when their loved ones are devastated by severe health problems and their savings are in turn devastated. And someone who thinks that they have been provident, someone who has prized their independence, can find themselves virtually wiped out.

I do not know what the answer is, but the committee is right in focusing on it, and I think that gives particular focus to the testimony that we are about to hear.

Thank you, Mr. Chairman.

Chairman MELCHER. Mrs. Fish, I noted that in responding to Senator Heinz, you said that your mother's determination is to make it to 100.

Mrs. FISH. Right. I believe she will.

Chairman MELCHER. You believe she will.

Mrs. FISH. Right—cost or no cost.

Chairman MELCHER. Will you tell her for me that I believe that elderly people contribute very much through their families and through their acquaintances to the quality of life and to the integrity of society of America; and that because they are aged, they have more experience than the rest of us.

I asked you if she still voted. Tell her I think she should. There is an election coming up before she reaches 100, and I think she should.

Mrs. FISH. I know she used to; her and Daddy always did.

Chairman MELCHER. Well, what this is all about is making a determination, and what Congress is all about is to make a determination of what are the priorities of America. Those of us on this committee feel rather strongly that health care for the elderly is a very high priority of the country. But nobody has more experience than someone who is almost 100 in making that determination.

So tell your mother for me that I want her to be part of the process of making that determination.

Mrs. FISH. Could I ask you a question?

Chairman MELCHER. Yes.

Mrs. FISH. Do you think that shows good reasoning in what I have mentioned about rather than the people who do not have to—like my mother, she does not have to go to a nursing home; she can be taken care of at home. And by sending her to the nursing home, I would have to pay that regardless. That is the only way they allow you to get in there, when you have to pay your own way. But if there were a fund to help, as I asked, does that show reasoning? The Government would still be better off and would not be paying the full extent of the patient's care in the nursing home.

Chairman MELCHER. Oh, yes. Providing home health care assistance is by far the best investment of anybody, because the patient—your mother, in this case—is more content at home, and you are more content in having her at home. And so providing that assistance is extremely vital and should be our first step.

Mrs. FISH. Right. This is for people like my mother who can; I am not judging people who cannot be taken care of at home. That is another story, as the other ladies showed us.

Chairman MELCHER. Mrs. Yelineck described the care that is needed for her husband at this particular time, which is probably more than you can do at home. But even so, his desire is to come home, and when he does, health care assistance must be available there. Mrs. Yelineck will not be able to handle it by herself.

Mrs. FISH. Are there funds at the present time, like the one health care that I have to hire the girls from there?

Chairman MELCHER. There are none at the present time.

Mrs. FISH. They are funded somewhat. Where does that come from, then, the 9 hours a week that I was offered, or given?

Chairman MELCHER. I think you are talking about a Michigan State plan. There are some home health care funds available for Mrs. Fish——

Mrs. FISH. It does not come through the Government per se?

Chairman MELCHER. But I think that is a Michigan plan, and there may be some Federal assistance in it—there is some Federal assistance in it, but it is done through the State, and each State decides how they are going to handle it, and they are going to contribute some.

Mrs. FISH. So it is State-funded, then, in other words?

Chairman MELCHER. There is some Federal assistance in it; 50 percent is Federal.

Mrs. FISH. I see.

Chairman MELCHER. But it is up to the State, then, to match that and then carry it forward. And what we are finding—it varies from State to State. In your case, it simply is not nearly enough. Did you say it amounted to 9 hours?

Mrs. FISH. Nine hours. They call it respite hours. Nine hours a week is all I could have.

Chairman MELCHER. Yes.

Mrs. FISH. That is all they had money for at the time.

Chairman MELCHER. Did that run out, or can you still get 9 hours a week?

Mrs. FISH. No. It runs out. And right now, there are not any funds to help.

Chairman MELCHER. We are just starting on our quest to be of assistance in passing catastrophic coverage, but so far what we are

finding out is that it is very limited, and in some States there is none, because they do not come up with their matching portion. Some States such as yours, Michigan, do match part of it, but that does not go nearly far enough to be of too much assistance for a person such as yourself.

I want to thank you very much, Mrs. Fish, for coming here today and giving us this picture of the circumstances that face you and your mother.

Mrs. FISH. Now, another question which has bothered me, if I could ask you Senators—who has the jurisdiction over closing a hospital? In the town where I live we have a beautiful, fairly new, up-to-date, modern hospital, and the doors are closed—a 100-bed hospital. The other hospital we have in my area is just newly-remodeled, an addition put on for $13.5 million. And the smaller hospital has been closed now for 2½ years.

Why couldn't these unused hospitals be utilized at a lower rate—as we call them, step-down units. I have been in nursing, and I think you understand the term, step-down units. This hospital is beautiful, modern, up-to-date.

Who has the jurisdiction over these hospitals closing? Is it the Government? What is it?

Chairman MELCHER. It is a combination of State and Federal Governments. The Federal Government will establish the standards necessary for a hospital to be able to receive Medicare and Medicaid patients. So to a certain extent we are the ones to talk to in the Federal Government, as well as Health and Human Services, which actually administers the laws that we cause them to administer. But it is a combination between the State and the Federal Government.

Mrs. FISH. Could those in some way be opened so that patients who have to go to the nursing home could go there, because these step-down units are really needed.

Chairman MELCHER. Well, it could be convalescent care, it could be a variety of things. And I think sometimes, we do not seem to use our good commonsense.

Mrs. FISH. Right, because they sure are not making any money with those doors closed and 100 beds. And in the new hospital with the $13.5 million addition, one complete floor is closed, with 68 beds empty, day after day. I am really curious. Being in nursing, I do not know—what is the reason for a whole floor in a hospital to be shut down, for 2 years now?

Chairman MELCHER. I cannot answer that one.

Mrs. FISH. Is that in the hands of the Government, some regulation that a certain amount of beds have to be closed?

Chairman MELCHER. I would not think so.

Senator HEINZ. Probably not. It was probably a decision of the board of the hospital. I assume it probably was a private nonprofit hospital?

Mrs. FISH. I think so. I do not know. It is a good-sized hospital.

Senator HEINZ. For the most part, it tends to be because in terms of acute care, there is not enough demand in that community, or sometimes it is because the reimbursement rates for certain kinds of care are just not adequate. That can be a Federal Government-created problem.

Mrs. FISH. That is a question that really bothered me. Then, is there encouragement for people like me to take care of a person in the home? Is there any good outlook?

Senator HEINZ. There is not nearly enough.

Mrs. FISH. I mean, will there be?

Chairman MELCHER. We think there will be a lot more, because we think that—in absolutely the best of all worlds, your mother would not be ill; but secondly, she does need a lot of care, and by far the best place is at home. So we hope we can generate more encouragement for exactly what you are doing.

Mrs. FISH. I hope so.

Chairman MELCHER. Thank you very much, Mrs. Fish.

We have a witness now from the insurance industry, Robert Shapland, the vice president of Mutual of Omaha Insurance Co., representing the Health Insurance Association of America.

Mr. Shapland, the committee very much welcomes your participation today, and we want to thank you for making the effort to come here today to be a witness.

STATEMENT OF ROBERT SHAPLAND, VICE PRESIDENT AND ACTUARY, MUTUAL OF OMAHA INSURANCE CO., ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. SHAPLAND. Good afternoon. I want to thank you for inviting me and giving me a chance to help in solving the problem of catastrophic costs. I think we all know that there are catastrophic costs, and we all want to work together to solve them.

I also want to thank you for having the snow. In Omaha we have not had any snow, and I love snow and I think it is beautiful outside—so thank you for that, too.

I am always pleased when I have attended hearings—I have not had a chance to attend too many—but I am always pleased at my strengthened vision or insight as to the work you guys are dedicated to doing and the way you approach the hearings. Every time I have been to a hearing, I have always thought that it is too bad that the people back home cannot see how you approach the hearings on a very fair basis and look for the answers without any foregone conclusions, and do an honest job.

Almost everything that you, Senators, have said here today and the witnesses have said today, I think is absolutely right. There are some problems that need to be solved. As Senator Heinz said, there are some potholes that need to be filled; there is education that needs to be conveyed—there are all kinds of things.

I know that this is a pretty knotty problem. I have spent a lot of time on this, and you are probably fairly new to it. The Health Insurance Association stands ready to help you in the education process.

I have made some notes during the hearing about the questions that were raised and statements that were made, so I thought I might respond to some of those. So my testimony might be sort of disjointed, but at least I am trying to help in any way I can. I know you will have some questions for me later, and I hope I can help you understand the insurance industry and the Government's and

industry's role in providing catastrophic care and where they are not providing catastrophic care.

The statement was made that the Government needs to take care of people as the last sort; people need to feel that they are taking care of themselves to the extent they can—that is right—and then, Government needs to realize where people cannot take care of themselves and step in. It is the same thing with Government's role in any other field, like transportation, food, national defense, or anything; where people cannot take care of themselves, the government steps in. And there are some areas here where the Government does need to step in and already has stepped in to some degree, and I think we need to ask ourselves what expanded role of stepping in does the Federal Government need to do.

Talking about education, I think you are absolutely right, and it has been made clear here at the hearing, that there are great misunderstandings about what Medicare does. I work with it every day in insurance, so I have learned it. But even for me it was a long process. Insurance of any kind is hard to comprehend.

Somebody made a comment about a burglary and what does the insurance company cover. I have the same problems, even though I am an actuary and work with insurance every day. Insurance is not an easy subject, and it takes a lot of education.

I think the Government has probably been remiss in its efforts on educating the public about Medicare. Surveys have shown that the vast majority of people in the United States think that Medicare pays for nursing care, when it does not, and some other kinds of care, and have relied falsely on their honest perceptions of what Medicare is.

I think the industry, on the other hand, has been way more active and deserves plaudits for its efforts at educating the public regarding Medicare. We go out and sell Medicare supplement policies and spend a lot of energy explaining to the public what Medicare pays, what our policies pay, what Medicare does not pay and what our policies do not pay.

We have developed, in conjunction with HCFA, buyers' guides that explain what Medicare is all about and what the Medicare supplement pays, and it also says that Medicare does not cover long-term care, for example, and that our policies do not.

Actually, when we sell a Medicare supplement policy, we have got to give the purchaser several pieces of paper that say what we do not cover and also tell him that the Government does not cover it, either. So we have gone out of our way to help educate the public and be honest about what we do not do. I think we have probably done more of that than any other industry. I do not know that the auto industry or any other industry have gone out there and said what their product does not do, like we are.

But that does not mean that that is enough. I think that it has been proven here today by the witnesses that there is just a lot more educating to be done.

There was a lot of discussion here about Medicaid and people having to be impoverished to get Medicaid. I think that that is something that you are going to really have to wrestle with—whether somebody should be able to keep $4,000 for burial before they go on Medicaid, and those kinds of questions. Those questions

will be tough, and I am glad I am not sitting in your seat, because we are talking about spending a lot of money at a time when the Government does not have a lot of money to support programs like that.

But I can say from my own personal perspective that I would like you to spend some of my money and tax me to help these people out. I am not speaking for anybody but my personal self now, but I see these needs, and I think you have got to bring yourselves to get some tax dollars out there to take care of some of these needs. It is not going to be an easy thing to do, but I think you are going to have to do it.

I think I might give you a little bit of insight regarding the Bowen proposal as it fills the catastrophic gaps that we need to cover. I guess I would generalize first and say that Bowen's proposal—and here, I think I had better define Bowen's proposal as his proposal for people with Medicare to expand the Medicare program—because he has made lots of different proposals that covers a whole gamut of options and so on, but——

Senator WILSON. Mr. Chairman, excuse me. I hate to interrupt, but I am having difficulty hearing Mr. Shapland. If you could speak a little louder, please.

Mr. SHAPLAND. All right. In the context of that portion of Bowen's proposal, I think you are going to find in your studies—and we have charts and things that might be helpful on this—that his proposal adds very little to the solution of the catastrophic problem, and that is for several reasons.

One, it addresses, as you have already talked about here today, only those types of expenses covered by Medicare. And as we have also talked about here today, Medicare has a limited laundry list of things it covers, and then a lot of things it does not cover.

Senator HEINZ. Excuse me, Mr. Chairman. Could I interrupt just to clarify something? A few minutes ago, you said that there were some problems, that you could not disagree with any of the kinds of problems that have been laid out here. And yet on the first page of your testimony, you say,

> If I could summarize for you the prevailing conclusion from our industry's assessments of Medicare and its present condition, I would have to say that we see no compelling need to begin a major overhaul of this program. In our opinion, the current combination of private and public coverage is serving the public well. So, since the system obviously is not "broken", a major "fix" hardly seems warranted.

My question is I do not understand why you were here a minute ago saying that you could not disagree with anything the witnesses were saying, and your statement says the opposite.

Mr. SHAPLAND. I am glad you asked that question because that is a confusing point. What we are saying is within the context of what Medicare is paying for, its laundry list of covered items, and only in that context, we agree that the Medicare and private insurance industries are providing catastrophic coverage, but——

Senator HEINZ. For those things that are being paid for.

Mr. SHAPLAND. Yes, right.

Senator HEINZ. For those things that are not being paid for, which include for a lot of people catastrophic coverage, things are still working well?

Mr. SHAPLAND. No, no.

Senator HEINZ. So things are working well when they are being paid for; when they are not being paid for, they are not working well.

Mr. SHAPLAND. That is right.

Senator HEINZ. We could have figured that one out.

Mr. SHAPLAND. The statement was limited, and maybe it was not clear, and I apologize if it was not clear. The statement was meant to convey that within the field of the items covered by Medicare, Medicare leaves some catastrophic gaps within its own field of coverage. There are lots of things it does not cover, but within the fields that it does cover, Medicare has some gaps, and those gaps have been closed by the private insurance industry and Medicaid and so on—and which I can explain.

Senator HEINZ. And—if the Chairman will allow me——

Chairman MELCHER. Yes, certainly.

Senator HEINZ [continuing]. You are saying that you feel, after having listened to the testimony of the first two witnesses, both of whom had "catastrophic coverage" and who clearly had serious problems, you believe that catastrophic coverage needs are being met by the private insurance they describe?

Mr. SHAPLAND. No, that is not what I said, sir.

Senator HEINZ. Well, I am just unclear as to what you are saying.

Mr. SHAPLAND. OK, I will try to explain it.

Senator HEINZ. I guess what you are saying is——

Mr. SHAPLAND. I think you are asking a good question. I think you are asking a very intelligent, good question.

Senator HEINZ. But I do not understand your answer.

Mr. SHAPLAND. So I will try to rephrase it so I can answer it. Within those types of coverage covered by Medicare, which is a limited laundry list that does not cover drugs, does not cover eye care, does not cover nursing care, aside from those items——

Senator HEINZ. It does not cover prescription drugs, which cost one of our witness $90 a month.

Mr. SHAPLAND. Absolutely, that is right.

Senator HEINZ. It does not cover doctor bills over and above those that Medicare will pay.

Mr. SHAPLAND. That is right, that is right.

Senator HEINZ. I mean, we are not talking about long-term care. We are talking about the catastrophic nature of a whole bunch of little things adding up to a huge burden that will break the camel's back.

Mr. SHAPLAND. We are all agreeing. It might not sound like we are agreeing.

Senator HEINZ. No, we are not. When you say you are agreeing——

Mr. SHAPLAND. No. You think we are not agreeing, but I want to explain that we really are agreeing. The insurance industry knows that all those things you mentioned need to be dealt with. And we do not ever intend to say—even though a statement there might have implied it, we did not mean to imply it. The insurance industry says all of those problems you just mentioned exist; they are not being taken care of by the Government or the private insurance industry. Now are we in agreement?

Senator HEINZ. What you say is a kind of sophistry, with all due respect. You are saying that when things are paid for, they are being taken care of; when they are not, there is a problem.

And what I asked you—and you did not respond to the question—is in your judgment, did the private catastrophic insurance that the first two witnesses indicated they had, was that doing a good job for them. And the answer is either it was doing a good job or it was not.

Mr. SHAPLAND. Some of the witnesses had no insurance, so obviously——

Senator HEINZ. I am talking about the two that did.

Mr. SHAPLAND. Well, to the degree that they buy a Medicare supplement policy, they have certain catastrophic coverages, and those are limited just like Medicare, and they still leave all the loopholes you just mentioned, and those are the ones you need to deal with.

Senator HEINZ. But how about the loopholes they mentioned?

Mr. SHAPLAND. The ones that they mentioned are ones outside of Medicare and Medicare supplement policies.

Senator HEINZ. Which they had—the first witness' husband worked for the Internal Revenue Service as a very highly qualified reader of, among other things, fine print. Both he and his wife are still trying to figure out how they got done in. You are saying not to worry.

Mr. SHAPLAND. I did not say that at all. I think they need to worry.

Senator HEINZ. You are saying it is working well.

Mr. SHAPLAND. No, I did not.

Senator HEINZ. You are saying it is not working well?

Mr. SHAPLAND. I say that there are all kinds of catastrophic needs out there not being met by the private insurance industry.

Senator HEINZ. Even when you have an insurance policy labeled "catastrophic coverage."

Mr. SHAPLAND. It is labeled a Medicare supplement policy, and it only supplements areas where Medicare is paying and covers the gaps of Medicare.

Senator HEINZ. Yet it does not, does it?

Mr. SHAPLAND. Yes, it does. It covers the gaps——.

Senator HEINZ. Well, I have taken too much time; I apologize.

Chairman MELCHER. No, that is fine. I think this is really the nuts and bolts of what Mr. Shapland can provide us. Let me restate it and see if my statement is correct, Mr. Shapland.

You are testifying on behalf of both Mutual of Omaha Insurance Co. and also the Health Insurance Association of America. What you are testifying is that Medicare goes so far, that there are Medigap policies that extend that only in the areas that Medicare now covers; is that correct?

Mr. SHAPLAND. That is correct.

Chairman MELCHER. And that you personally believe that we should go much farther, and that your vote and your tax dollar, as far as your vote is concerned, could wisely be used to go farther for the elderly; is that correct?

Mr. SHAPLAND. In the area where people cannot take care of themselves, I think we have to spend some tax dollars.

Chairman MELCHER. In exactly the instances of the witnesses that we have heard?

Mr. SHAPLAND. Sure.

Chairman MELCHER. All right. Might I ask you one more question at this point. Is that testimony that you have just given there, your feeling and your tax dollar and your vote, or is that the feeling of the Health Insurance Association of America?

Mr. SHAPLAND. The Health Insurance Association of America recognizes that there are people who cannot afford private insurance, just like they cannot afford food or clothing or shelter; and the Government needs to step in and take care of those people.

We have had lots of testimony that even though there is such a Government program that it also has all kinds of loopholes that you have to deal with. And we are asking you—we are on your side, and we think they need to be examined, and the Medicaid Program modified.

Chairman MELCHER. The Medicaid Program what?

Mr. SHAPLAND. The Medicaid Program to the extent that it is not doing the job that it was intended to do needs to be modified, and we commend you for looking at the shortfalls of the Medicaid Program and fixing them.

Chairman MELCHER. Please proceed.

Mr. SHAPLAND. I know it might be confusing. I was only trying to explain what the "potholes" were, as Senator Heinz mentioned, what the potholes are that do not need fixing, and what the potholes are that do need fixing.

Senator HEINZ. And "black holes" as well as potholes.

Mr. SHAPLAND. Black holes, potholes. You are absolutely right. There are these potholes out here, and I commend you for examining and look for those potholes and finding out what can be done about them. We are all together in this. It is a heck of a job, and we commend you for your effort.

One pothole that does not need to be fixed is the one that Dr. Bowen says we need to fix. I think he is expending his energy in an area where it does not need to be spent, because that is one pothole that has already been fixed. There are a lot of potholes out there that have not been fixed, but that one has.

Chairman MELCHER. Well, he recommends, I think $4 a month additional.

Mr. SHAPLAND. Right.

Chairman MELCHER. Which is $48. Would $48 spent in the private field do as much?

Mr. SHAPLAND. It was $4.95, I believe.

Chairman MELCHER. Five dollars, or $60 per year.

Mr. SHAPLAND. Right.

Chairman MELCHER. Would $60 spent in the private field do as much as what Bowen proposes?

Mr. SHAPLAND. At $60, we can sell the same thing Bowen proposes. There is a misconception about what most people want to buy and what was said here about somebody dropping a policy because it was $60 a month instead of $5 a month—well, the insurance industry has a wide range of premiums. We have all kinds of policies. We have policies that are $11 a month, or $60 a month, or $100 a month. You know, it depends on what kind of benefits you want.

Chairman MELCHER. Well, I have concluded one thing, and I want to be sure I am right. What you are really recommending is that we go beyond the Bowen proposal to take care of some of the gaps that were evidenced today.

Mr. SHAPLAND. That is right. What I want you to realize is that the gaps that he is trying to close have already been closed, plus they are very minor gaps in any event, even if they had not been closed, compared to—look at the chart over there; that is all you have got to do—and you see that Mr. Bowen's proposal is a scratch in the bucket or a drop in the bucket or whatever you want to call it, compared to what the catastrophic needs today are.

I mean, for people who are spending money who are not covered by insurance programs, it is nursing home care, and Bowen does not make any change in the nursing home coverage.

Chairman MELCHER. And home health care, too.

Mr. SHAPLAND. Home health care, respite care. All of those things need to be wrestled with. We have to decide what are the true catastrophic needs of the people, but also how do you finance them, and then how do you change health care to minimize those costs besides. And home health care and respite care and those things were suggested here today, and those are good suggestions or ways of trying to minimize the health care costs that are out there, and let people take care of their own, but have some relief and so on, to keep people at home.

Chairman MELCHER. Mr. Shapland, I am sure you have paid attention to and gone through very carefully the booklet, the paper published by the Harvard Medicare Project in March of last year that said—I think they titled it, "Medicare Coming of Age." In that, they say that one-quarter of all Medigap plans are worthless because they simply duplicate existing Medicare coverage.

First of all, does the Health Insurance Association of America take care of everybody? Does everybody that sells Medigap insurance belong to this association?

Mr. SHAPLAND. No. The Health Insurance Association of America represents the majority of the health insurance business, but not all of it.

Chairman MELCHER. Is that statement of theirs in this study correct, that one-fourth of all Medigap policies merely duplicate what is already there, and coverage that is already there in Medicare?

Mr. SHAPLAND. I have not read the report, but that statement—maybe it is being taken out of context—I would say it is a blatant lie.

Chairman MELCHER. It is what?

Mr. SHAPLAND. A blatant lie, unless it is being taken out of context.

Chairman MELCHER. Oh, I just assumed that probably you knew a lot more about this report than I do.

Mr. SHAPLAND. No, I have not read the report.

Chairman MELCHER. Would you mind digesting it for us?

Mr. SHAPLAND. Let me explain why I say that it cannot be true. The Health Insurance Association of America, the National Association of Insurance Commissioners, people from HCFA, people from AARP—just a broad spectrum of people—sat down many years ago and said if companies are going to sell a Medicare sup-

plement policy, what should that policy do and not do. And there was broad agreement about what it should do and not do. So all the States have laws saying what Medicare supplement policies can do and not do. And by law, there is no duplication of Medicare by a Medicare supplement policy. So I do not see how they can make a statement like that.

Chairman MELCHER. Would you mind digesting it? I think there are only 80 pages or so. Would you mind digesting it and giving us your reaction to it, because I suppose it has a certain amount of prestige, and we need to fully understand——

Mr. SHAPLAND. I would say that that statement somehow had to be taken out of context, or I did not understand it.

Chairman MELCHER. Yes, and that is a danger we are all prone to fall into. It would be helpful for us on the committee if we could have your reaction.

Mr. SHAPLAND. I will be glad to serve your committee in that way.

Chairman MELCHER. All right, thank you.

One last thing. Would you recommend that standards be established for private insurance coverage to complement Medicare? We have already got the standards to a certain degree, that require Medigap policies attempt to describe their coverage. If we are seeking to close some of the real gaps, the real catastrophic gaps that now exist between private insurance and Medicare, shouldn't we have some sort of a requirement established that private insurance might attempt to pick up what is now totally uncovered, such as in many instances, nursing home or home health care?

Mr. SHAPLAND. I think I understood you to say you understood that Medicare supplement policies do have in every State a legal standard that we have to follow.

Chairman MELCHER. Yes.

Mr. SHAPLAND. OK. But as I mentioned earlier and we got into a good dissertation on, those Medicare supplement policies only cover the types of medical expenses covered by Medicare itself, and when Medicare runs out or has coinsurance, then these policies fill in those gaps.

But like you mentioned, nursing homes are not covered. Medicare supplement policies do not cover nursing home care.

Chairman MELCHER. Or home health care.

Mr. SHAPLAND. Or home health care and so on. Actually, Medicare pays 100 percent of the home health care it recognizes, but sometimes Medicare does not recognize certain kinds of home health care.

As far as nursing home care is concerned—and that is the great, big area of catastrophic cost—the National Association of Insurance Commissioners spent some time with the industry and other people on this very issue that you raised and just adopted some standards for nursing home policies.

Chairman MELCHER. Would you provide those for us?

Mr. SHAPLAND. Sure.

Chairman MELCHER. All right. Thank you very much, Mr. Shapland.

[The prepared statement of Mr. Shapland follows:]

Statement

of the

HEALTH INSURANCE ASSOCIATION OF AMERICA

on

CATASTROPHIC HEALTH CARE COSTS

Presented by

Robert Shapland

Vice President and Actuary
Mutual of Omaha Insurance Company

Before the

Senate Special Committee on Aging

January 26, 1987

Washington, D.C.

I am Robert Shapland, Vice President and Actuary for the Mutual of Omaha. Today I also represent the Health Insurance Association of America. The HIAA is a trade association, representing some 335 insurance companies. Our members write over 85 percent of the private health insurance provided by insurance companies in this country. Many of these companies, including my own, also design and underwrite private insurance plans that coordinate with the Medicare Program. Mutual of Omaha has many years of experience in that particular business.

The HIAA appreciates this opportunity to comment on proposals for financing catastrophic health care under Medicare. We commend you, Senator Melcher, and this committee for exploring this issue, however, we encourage you to look beyond mechanisms for financing acute hospital and medical care. Acute hospital/medical care expenses are not the predominant cause of catastrophic expenses among the aged. In fact, approximately 70 percent of Medicare eligibles have catastrophic private Medicare Supplement coverage. The elderly are most at risk for chronic long term care and outpatient drug expenses — items not covered by Medicare. Specifically, 42 percent of the elderly's total out-of-pocket expenses are for nursing home care. Long term care is a complex health policy issue requiring thoughtful and balanced debate.

If I could summarize for you the prevailing conclusion from our industry's assessments of Medicare and its present condition, I would have to say that we see no compelling need to begin a major overhaul of this program. In our opinion, the current combination of private and public coverage is serving the public well. So, since the system obviously is not "broken", a major "fix" hardly seems warranted.

From all indications, the joint Medicare/Medigap program enjoys a remarkably high degree of public approval and meets acute care needs not covered by Medicare. The Medicare program is being efficiently administered by a successful partnership between the Health Care Financing Administration and the private insurance industry. You should be mindful, however, that in the past few years, underfunding of Medicare carriers and intermediaries is seriously undermining that venture in cooperative management.

The fact that seventy percent of Medicare beneficiaries use private supplemental insurance to fill the program's ever increasing deductibles and co-payments attests to its success and to the practical accommodation of public and private interests. Since an additional 10 percent of the elderly are covered by Medicaid, only 20 percent of those over 65 are without protection against gaps in Medicare. It seems to me that this points out an area where some limited government action may be appropriate; i.e., to further assist those few who are not able to cope financially with the rising coinsurance, deductibles, and out-of-pocket costs associated with Medicare via the purchase of supplemental insurance. Although this problem for the elderly poor should not be underestimated, it should not be the sole reason for a major overhaul of a smoothly operating program. Limited financial aid to those few indigent that fall outside of current Medicaid qualification rules is the only supplemental coverage area where a problem exists and a solution is needed.

CATASTROPHIC PROTECTION UNDER EMPLOYEE GROUP INSURANCE

Protection against catastrophic health expenses are the major concern of the private health insurance industry. Private health insurance provides protection against health care expenses for an estimated 190 million Americans of all ages. Of all Americans covered by private health insurance, it is estimated that over 160 million are protected by programs that are comprehensive in nature, providing coverage for both in and out of hospital expenses.

For the working population, studies of group employee benefit plans among commercial health insurance companies have shown trends toward adoption of plan features that will both help contain costs and improve the comprehensiveness of the plans:

— A higher percentage of employees today than ever before have larger maximum benefit levels with nearly 80% having maximum benefits of $1,000,000 or more.

-- 91% of employees have out-of-pocket expenses limited to $2,000 or less.

— Over 99% of insured employees have coverage for inpatient expenses associated with mental and nervous disorders.

— Over half of all insured employees have coverage for home health care and almost two thirds for second surgical opinions.

STATE HIGH RISK POOLS FOR UNINSURABLES

We cannot fail to mention that not everyone can buy individual insurance products in the private marketplace. The commercial health insurance industry has long supported legislation to make health insurance available for persons considered uninsurable in the individual health insurance marketplace. This legislation, S. 1372, S.2402, and S. 2403 introducted during the 99th Congress by Senators Heinz, Kennedy, and Durenberger, respectively, would encourage states to establish qualified risk pools for uninsurables, including persons unable to buy health insurance coverage due to such chronic health conditions as diabetes, heart disease and AIDS. The industry expects similar legislation to be introduced again this year.

Several models for an effective risk pool already exist. Ten states currently have some form of risk pool offering comprehensive major medical insurance to high risk people. The pool operates like any other private insurance plan. If the pool experiences losses, those losses are shared by all the insurers in the state. The pools would be established in the states and regulated like other state insurance. The federal legislation simply establishes minimum standards based on the experiences of successful state pools and ensures a fair distribution of pool losses.

Most important, the state high risk pool proposals would ensure the availability of health insurance to all Americans, regardless of health condition, with minimum federal regulation, and at no cost to the federal treasury.

MEDIGAP INSURANCE: A PUBLIC/PRIVATE SECTOR SUCCESS STORY

For the nation's elderly, the HIAA believes that Medicare together with the private health insurance industry are doing a good job in providing protection against the medical costs of acute catastrophic illnesses. We are proud of our record in providing supplemental coverage to the Medicare program so that the Medicare beneficiary can feel confident that his or her acute health care needs will be met in the future.

There have been some assumptions in the past that private insurance is confusing and duplicative. This premise is invalid. A 1983 HCFA study of the effectiveness of state regulation of Medigap insurance found that duplicative coverage was rare. Further, the October 1986 GAO study prepared for the House Ways and Means Health Subcommittee concluded that state regulation of the Medigap business was working well in controlling sales abuses. Of the millions of policies presently in force, we are aware of only a handful of alleged violations brought to the attention of HCFA. Upon investigation, the majority of these cases were closed because they didn't warrant federal action. HCFA coordinates review of alleged violations of federal statutes together with the Federal Trade Commission and the Postal Service. The HIAA feels that this process is adequate and that no new federal regulatory activities are warranted.

HCFA's and the GAO's findings reflect the tremendous efforts made by state insurance regulators and the insurance industry in response to events of the late 1970s concerning agent sales. In 1977 individual state insurance

regulators accelerated agent enforcement procedures to curtail sales abuses. In 1979 HIAA's president wrote all member companies and insurance regulators calling for joint efforts to remedy sales abuses by a few, but nevertheless embarrassing number of agents. That same year, the National Association of Insurance Commissioners appointed a special consumer-oriented Advisory Committee on this issue, which included representatives from HEW, the FTC, consumer and senior citizen groups, and members of the insurance industry. As a result of the Advisory Committee's efforts, the NAIC then adopted model state standards later embraced on the federal level in the 1980 Baucus Amendment. Consequently, virtually all Medicare Supplement policies now on the market meet or exceed those standards.

Additionally, this multi-interested Advisory Committee developed the Guide to Health Insurance for People with Medicare, presently available through HCFA. Current state law requires that this simplified buyers' guide be provided to purchasers of Medicare Supplement coverage, along with an outline of coverage depicting gaps in Medicare coverage and how particular Medicare Supplement policy benefits relate to these gaps. Also, current law requires delivery of a special notice when replacement or addition to existing coverage is involved. The HIAA would be glad to furnish the Committee with examples of these materials upon request.

Further, state law requirements dealing with Medicare Supplement policies offer the beneficiary the opportunity to return a policy within 30 days of purchase, as well as receive a full refund. Also, state laws dealing with Medicare Supplement policies require high loss ratios, truth in advertising, fair trade practices (including sales, underwriting and claims practices, and simplified policy language requirements), and other valuable consumer protections.

To ensure that all of these controls are adequate, an NAIC subcommittee recently surveyed state insurance departments regarding citizens' complaints related to Medigap insurance. This survey indicated that the limited number of complaints were not the result of any deficiency in NAIC model laws.

This same type of process outlined for Medicare Supplement in protecting the aged is being undertaken by the insurance industry and the NAIC regarding private long term care insurance. Current efforts center upon developing regulations that will appropriately control the marketplace, yet facilitate experimentation and exploration of what consumers want to purchase in the long term care field.

WHAT MEDIGAP POLICIES COVER

Private Medicare Supplemental policies typically cover such out-of-pocket costs under Medicare as co-payments and deductibles for hospital and doctor services. In keeping with the Baucus Amendment to the 1980 Social Security Disability Act (P.L. 96-265), the states now require Medicare Supplement policies to meet certain minimum standards, as follows:

-- Coverage of Part A coinsurance for Medicare eligible expenses for hospitalization from the 61st day through the 90th day in any Medicare benefit period;

-- Coverage of Part A coinsurance for Medicare eligible expenses incurred during use of Medicare's lifetime hospital inpatient reserve days;

— Upon exhaustion of all Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization for up to an additional 365 days; and

— Coverage of 20% of the amount of Medicare eligible expenses under Part B, subject to a maximum calendar year out-of-pocket deductible of $200 and a maximum benefit of $5,000 per calendar year.

Bear in mind that these are purely minimum standards, and that insurance companies are not precluded from the inclusion of higher levels of coverage or additional benefits. In fact, the vast majority of plans exceed these minimum standards.

SUGGESTIONS FOR ENHANCING THE VALUE OF MEDICARE AND MEDIGAP BENEFITS TO BENEFICIARIES

If the federal government wants to enhance the value to beneficiaries of their Medicare benefits as well as their private Medicare supplement policies, the Health Care Financing Administration could do much more to identify for Medicare beneficiaries those physicians and other providers who regularly accept assignment. By helping beneficiaries find Medicare participating physicians, HCFA could greatly relieve the high insurance costs and out-of-pocket costs that stem from provider balance billing. HCFA could publish directories with the names of participating physicians and provide toll-free hotlines. It could also develop incentives for electronic billing of physician claims and for streamlining the coordination of billing for Medicare and Medigap benefits.

The HIAA also endorses Medicare's use of more stringent cost containment techniques to help keep that program solvent. For example, we encourage Medicare to be more aggressive with utilization review, pre-admission certification and mandatory second surgical opinion programs. These are all steps being used more routinely in private managed health care plans.

TAX INCENTIVES FOR PRE-FUNDING RETIREE HEALTH BENEFITS

One important way both to help the elderly poor and to complement the Medicare program would be to encourage more employers to provide health benefits to their retired workers.

The U.S. Department of Labor reports that currently, only 37 percent of employees in large and medium-sized companies will receive employer-provided health benefits to supplement Medicare upon retirement. Although this number is expected to grow, coinciding with the growth in the size of the elderly population, federal tax policy is a major reason why many more employers are choosing not to do more for retirees.

The Deficit Reduction Act of 1984 placed limits on the tax advantages of pre-funding retiree health benefits. I urge Congress to consider the wisdom of federal tax policy which discourages employers and employees from entering into financial arrangements today, which would generate greater private capital for the health care needs of tomorrow's elderly. In our minds, employers should be encouraged to provide such benefits by allowing them maximum flexibility and positive incentives to respond to the growing financial needs of their retirees. Pre-funding for retiree health care needs

not only helps relieve political pressure to expand government financing of long term care, but promises to be one of the truly promising ways to promote long range financial planning helpful to the develop of an insurance market for a long term care insurance product.

In short, DEFRA's tax provisions on pre-funding retiree benefits is causing employers to curtail the funding of retiree health benefits. I urge Congress to examine this issue.

PROPOSALS FOR RESTRUCTURING MEDICARE

Various proposals have been advanced to expand or restructure the Medicare program. In assessing this issue, the HIAA feels that various problems under the Medicare program should be prioritized.

The first priority of Congress should be to ensure the adequate financing of current Medicare benefits. Next, Congress should reinstate originally promised benefits and provide sufficient funding. Both efforts will entail hard decisions regarding who should bear this cost. That Medicare no longer provides for originally promised acute care coverage is apparent in the fact that in the last ten years, hospital inpatient coverage has decreased from 75% to 65% of charges, while Part B coverage has dropped from 65% to about 57% of charges. Further, Medicare extended care benefits cover only 2% of all nursing home costs. Returning Medicare benefits to original levels will cost billions of dollars. This revenue should be found before Congress exacerbates the above-mentioned problems still further by adding new benfits.

Finally, given that Congress finds adequate funding to meet these priorities, it could then turn its attention to the catastrophic needs facing a limited number of citizens who cannot afford to purchase private coverage which fills in Medicare coverage "gaps". Since the vast majority of Medicare beneficiaries can afford private supplemental insurance, solutions should be limited to financing catastrophic benefits for the limited number of near-poor not covered by Medicaid. Tax subsidies for those who are partially able to purchase private insurance would limit the financial burden on the federal government.

CATASTROPHIC COVERAGE NEEDS REGARDING LONG TERM CARE

Tragically, the problem few elderly fail to anticipate is that neither Medicare nor private Medicare supplemental policies cover long term custodial care. Proposals to expand Medicare benefits are not a solution because acute care expenses are not the usual cause of catastrophic expenses among the elderly. The real problem is chronic long term care. Based on a recent study financed by the National Center for Health Service Research, for those aged who spent more than $2,000 out-of-pocket, 81 percent of their additional expenses were for nursing home care.

The costs associated with long term care insurance are so vast that it is hard to imagine how the federal government could finance every citizen's needs in this area. Thus multiple financing mechanisms must be utilized. Those with means will have to provide for their own protection through private insurance. Those with limited means might receive tax subsidies to purchase

private insurance. For some of the poor, the Medicaid program is already financing long term care, but the program may need to be expanded to cover all poor and not just the categorically poor.

INSURANCE INDUSTRY INITIATIVES REGARDING LONG TERM CARE

About four years ago, an HIAA Task Force was established to explore this issue. A report, "Long Term Care: The Challenge to Society", produced by the Task Force, is available upon request. In December 1984, an industry-wide conference was held to build on the task force report and to expose industry representatives to the range of long term care issues from a variety of perspectives. In November 1985, the HIAA joined other national organizations representing the aged, providers and payers in sponsoring a national conference entitled: "Private Long Term Care Insurance - the Emerging Market." The proceedings of that conference are available from our Public Relations Division.

In its deliberations, the HIAA Long Term Care Task Force has identified some of the problems associated with the development, administration and marketing of a long term care product. These problems are not trivial and solutions are not easily achieved. As possible solutions are found, they must be tested in the marketplace to see whether or not they will work.

Industry representatives have participated in numerous conferences and hearings called to bring interested parties together to begin a broad based effort to resolve some of the problems. In addition, individual companies are exploring and/or are entering into the private sector market for long term care insurance.

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A recent HIAA survey of our member companies has found that 12 companies offered an individual indemnity long term care insurance policy as of June 1986. Since June, four more companies have entered this market. We have defined this type of policy as one which covers nursing home stays and/or home health care for not less than 12 consecutive months. Because many companies have just entered the market, it is too early for them to have current information on the number of policies sold. However, those companies having data show that there were about 130,000 policyholders as of January 1, 1986. Further, for those companies with greater enrollment experience, the average current age of a policyholder is 75. At least one long term care insurance product is available in every state except Connecticut. However, since then, at least two companies have filed long term care products in that state. Typically, four to five HIAA companies are selling policies in each state.

Services currently covered by long term care policies include skilled, intermediate, custodial, and home health care. Of the 12 policies analyzed, all offer skilled nursing care, 10 offer intermediate nursing care and custodial care, and 8 offer home health care. The maximum benefit period for a typical policy is 3 years, although a substantial number offer 5 years of coverage. Finally, companies typically offer policies with a choice of either 20 or 100 days during which a person must be confined to a nursing home before insurance payments can begin.

In total, 15 additional companies are developing new products. Many of these are described as "group insurance" (i.e., marketed to groups with little

or no individual underwriting). At least one company has filed for approval of a group policy.

It appears that new products are being introduced with increasing frequency and that the next generation of long term care insurance products will be more diverse than the current one. Each venture into the marketplace provides the industry with additional information on the feasibility and viability of private long term care insurance coverage.

Long term care may well be the major health policy issue in the coming decades. The industry and individual companies are exploring the problems and seeking solutions. Both government and private resources are required to meet current challenges and plan for the future needs of our expanding elderly population. The Health Insurance Association of America stands ready to join in the public debate and offers its assistance to this committee as you deliberate this pressing national problem.

Chairman MELCHER. Senator Heinz.

Senator HEINZ. I will just take a moment because I asked probably more than my fair share of questions earlier. Mr. Shapland, one of the recommendations you made in your testimony has to do with getting employers to fund retiree health benefits. How much is that going to be a solution to the problem?

Mr. SHAPLAND. It is hard to tell. I do not know if anybody would know the answer to that. All we do know is that when employers see a need for retirement income, then when they fund for that, IRS and tax laws and so on will recognize that as a legitimate business expense.

But if an employer also said, well, we need to recognize that our retirees when they retire are going to have long-term nursing home care costs and expenses like that that are catastrophic and want to fund for that, then IRS says no.

Senator HEINZ. The Brookings Institute is studying the viability of various financing options for long-term care; that is the Alice Rivlin Task Force. I am told that their preliminary analysis shows that private insurance is unlikely to be purchased by very many Americans. I guess right now, there are about 130,000 policies outstanding, offered by about 12 companies.

How do we deal with the apparent lack of marketable long-term care insurance policies by the private sector, namely your industry?

Mr. SHAPLAND. I thought the answer to that was pretty well demonstrated here today and discussed, and that was education. You know, people when they are 40 years old——

Senator HEINZ. I beg your pardon?

Mr. SHAPLAND. It is an educational process, as was discussed here. People age 40 without a lot more education do not think about, gee, I have got to start funding for long-term care. They might think a little bit about pension costs or something like that, but they do not visualize themselves being in a nursing home.

So it fits an educational process that I think is tied in with the whole gamut of catastrophic costs. There is a big educational process that needs to take place regarding what Medicare pays, what Medicaid pays, what is not covered, where you need to buy some insurance. As far as the number of people covered currently by the private insurance industry by private long-term care policies, that is a very low number, because it is in its infancy. Long-term nursing home care policies have just begun to be sold so we have not really been given a chance.

Part of the reason that we have not sold nursing home care policies up to this time is because we did not have any actuarial statistics, and there is quite a risk involved in engaging in a market where you have no data.

Senator HEINZ. Well, I understand the difficulties in pricing, but in view of the study that was done last year by the American Association of Retired Persons, which shows roughly 79 percent of senior citizens think that Medicare is going to cover their health care needs, including nursing home care. I would scarcely describe that as an educational problem. It is like everybody believing that the world is flat when in fact it is round. And to say that in 1492,

Columbus was dealing with an educational process is to slightly understate the problem.

Mr. SHAPLAND. I am sorry, but I do not follow that. I would think it would be an educational process.

Senator HEINZ. Well, what I am saying is when you have most of the people, including people who have learned the hard way, thinking they are going to be taken care of, and they are not, that means that there is a body of conventional wisdom out there that is so broad and so deep that it defies what we think of as education. I do not know what the next hierarchy of convincing people that the world is round rather than flat has to do with, but it is deeper than—there is just a little prejudice we have to overcome here.

Mr. SHAPLAND. It seems like you are saying that it is beyond education. I would hope it would not be. You might be right that we can educate the people.

Senator HEINZ. Well, we have had Medicare for 20 years. The coverage on it has not been expanding.

Mr. SHAPLAND. But how much energy has the Federal Government spent on telling people that nursing home coverage was not covered so there was not a misunderstanding?

Senator HEINZ. So we should have an educational program that says the Federal Government does not cover nursing home care, and so do not get sick?

Mr. SHAPLAND. The private insurance industry does, by the way. The private insurance industry says our policies do not cover long-term care. Is the Federal Government doing that, saying our program does not cover long-term care?

Senator HEINZ. So what should anybody be doing about the problem? You say it is an educational problem.

Mr. SHAPLAND. First of all, you have to understand that you need the insurance and that you do not already have it. You are not going to go out and buy private insurance if you think you already have it. We are doing our part, and we will be glad to do more, and we ask you to do the same.

Senator HEINZ. Well, what should we be doing?

Mr. SHAPLAND. First of all, both of us have to help educate the public that they do not have the coverage, so that they purchase the coverage out there. I think the last survey said there were something like 70 companies offering long-term care insurance.

Senator HEINZ. Well, I understand we both have to somehow educate the public. How do we do it?

Mr. SHAPLAND. I am not in the education business.

Senator HEINZ. Senator Melcher is holding a hearing, which is not unlike hearings I held over the last 6 years, to try to educate the public that when it comes to long-term care, the typical American has this insurance "bulletproof vest," but as I said, it has got a big hole over the heart, because it does not cover long-term care. We have been trying—Senator Melcher has been a party to those efforts. He and I served in the House together. We have been aware of that problem. We have been trying to dramatize it for in excess of a decade. You know, we need some ideas as to how we can do a better job, because we are not doing a very good job at this point.

Mr. SHAPLAND. I think we are in absolute agreement.

Senator HEINZ. Yes, but how do we do a better job?

Mr. SHAPLAND. OK. I guess if I were in your position, I would look for somebody in advertising to help me, because I am not an expert in that, and you probably are not either. I do not know if you use full-page ads, if you use newspapers, broadcasting—I do not know what you do. That is up to people who are experts in educating people and advertising and so on. I think we need to look for help in that area; I agree with you.

Senator HEINZ. Just call up Doyle-Dane-Bernbach and buy some advertising.

Mr. SHAPLAND. Sure.

Senator HEINZ. Thank you.

Chairman MELCHER. Senator Pressler?

Senator PRESSLER. Let me first of all welcome you here to this committee. I know you are associated with Mutual of Omaha, which is headed by Mr. V.J. Skutt, who is formerly from South Dakota, and I think he is one of the most honest and finest men—we are very proud of him. He comes back to South Dakota about once a year to give a speech.

The point I am making through that is that we seem to have a problem here, but I do not think it is necessarily the fault of the private insurance companies. If there is misinformation, we should root it out. But there is nothing wrong with being in business. You have got to make a profit. I think it is easy to "beat up" on the health insurance companies, but I do not know if that does much good, especially since you are here with crutches, so we should not beat up on you.

Mr. SHAPLAND. Go ahead and beat on me.

Senator PRESSLER. The thing we are trying to find here is the truth and who is responsible. In many areas, as you have pointed out, the private health insurance companies appear to be doing what they say they are doing, and they are not misleading anybody.

But there are still people—and we have heard cases this morning of people who are falling through the cracks somehow. I am just embarking on a visit to all 66 counties in my State, which will take a while to get done if I want to keep my voting record up here in the Senate. I am sure that in many of those counties, I will meet people who will say that they cannot buy private health insurance for one reason or another, and they are left out in the cold. So we do have these catastrophic cases.

I want to just address a general question to you about the group you represent—and I know that you are an easy target for criticism. But does the profitability of the health insurance companies that you represent exceed the profitability of other insurance companies? Could you explain a bit of that?

Mr. SHAPLAND. Sure. I do not know what the figure is, so I will just make a rough approximation, and I do not know that it is too critical. But I would say maybe half or a lot more of insurance is sold by nonprofit insurance companies.

Senator PRESSLER. By nonprofit companies?

Mr. SHAPLAND. Nonprofit insurance companies, like Mutual of Omaha. They are designated "mutual" companies.

Senator PRESSLER. So your company is a nonprofit company?

Mr. SHAPLAND. Right. A mutual company is owned by its policyholders and is not in the business to make a profit.

Senator PRESSLER. So the companies that you are representing today, are they nonprofits?

Mr. SHAPLAND. Yes, if it is a mutual. Anytime you see a name like Mutual of Omaha, Mutual of New York. Prudential is also a mutual company, and so on.

Senator PRESSLER. OK. So if you start making a profit, then you pay a dividend; is that right?

Mr. SHAPLAND. Life companies pay dividends. But health insurance dividends are very rare compared to—like you are used to dividends on life insurance—and that is because health insurance companies have a different operating philosophy regarding health insurance than life insurance. In life insurance, you normally put loadings in your premiums so that you have margins and then return some of those margins in dividends. Health insurance is usually run on a basis where you try to price it exactly right so that you do not have margins.

Senator PRESSLER. Before you can offer an insurance policy to someone, there has to be some law of averages. If you started writing insurance policies for all these catastrophic cases, you would be losing a good deal of money; is that correct?

Mr. SHAPLAND. No. The insurance industry has sold million-dollar major medical policies to almost every employer and individuals who want to purchase it. We run that risk, and right now, most of us are surviving. There are some companies that have had problems with it.

Senator PRESSLER. But if you begin to provide full insurance coverage for all the situations and expenses we have heard this morning, you would lose money; is that not true, unless you raised your premiums substantially?

Mr. SHAPLAND. Well, the formula is that if you charge a premium that is adequate to cover your expenses and claims, then you do not lose money, and if you do not charge that much, you will lose money.

The insurance industry presumes that it can sell long-term care insurance and be okay. Otherwise we would not be doing it.

Senator PRESSLER. So if these witnesses that you have heard this morning had purchased that at the right time, they would not be having the problems they are having today?

Mr. SHAPLAND. Right. And if you are talking specifically about long-term care and the insurance companies now developing those policies, that is right.

Senator PRESSLER. Do you feel that the three witnesses who testified before us today are the exception rather than the rule?

Mr. SHAPLAND. No. I thought they sounded like average cases. They are the ones that were faced with the catastrophic costs in areas not covered by Medicare and Medicare supplement policies. When Medicare was designed, I do not know if it was on the basis of what the Government knew that they could afford and not afford to cover, and cost containment rationale and so on, they chose not to cover out-of-hospital drugs, they chose not to cover long-term care, and so on. And that is why you are here today.

Those problems are real problems faced by the average person out there, and we need to work for solutions. And we want to work with you on that.

Senator PRESSLER. How much is the average monthly premium for a typical Medicare supplement, and how much is it for a catastrophic policy?

Mr. SHAPLAND. Well, a Medicare supplement policy, by legal definition of the minimum standard, is a catastrophic policy.

Senator PRESSLER. All right. How much is an average monthly premium?

Mr. SHAPLAND. I think the average premium, for the catastrophic portion, is something like $60.

Senator PRESSLER. Sixty dollars?

Mr. SHAPLAND. Right. But that is because most of the people who buy Medicare supplement policies are not happy with only catastrophic; they want to get first-dollar coverage, not just catastrophic.

Senator PRESSLER. They want to get everything covered.

Mr. SHAPLAND. They want to get everything covered under their policy. You have got to remember every time I talk about Medicare supplement, we are talking about only those kinds of expenses covered by Medicare. Senator Heinz was rightfully confused about that. But in that realm of Medicare coverage and Medicare supplement policies which cover the same kinds of expenses, most people are not happy just buying the catastrophic long-tail costs, if you want to call them that. They want first-dollar coverage, and they pay more.

But the insurance industry has a whole set of policies with smaller premiums that are catastrophic. But every Medicare supplement policy is catastrophic. It is just you pay more if you want first-dollar coverage.

Senator PRESSLER. On page 3 of your testimony, you state that, "Limited financial aid to those few indigent that fall outside of current Medicaid qualification rules is the only supplemental coverage area where a problem exists and a solution is needed."

Mr. SHAPLAND. Again that was within the context of the Medicare realm of things.

Senator PRESSLER. Within the Medicare realm. OK. So you would amend that statement to that effect?

Mr. SHAPLAND. Right. You see, this statement was in the context of Medicare, and maybe it did not come across to some of you that way.

Senator PRESSLER. And you also state on page 3, "The fact that 70 percent of Medicare beneficiaries use private supplemental insurance to fill the program's ever-increasing deductibles and copayments attests to its success and to the practical accommodation of public and private interests."

So your feeling is that if that were 100 percent of the Medicare beneficiaries use private supplemental insurance, that that would solve the problem?

Mr. SHAPLAND. It would solve only the catastrophic problems relating to the types of coverage covered by Medicare—not long-term care, drug care, and so on.

Senator PRESSLER. So we would still have a problem.

Mr. SHAPLAND. I am sorry that that statement was misleading. Now that we are engaged in this conversation, I can see that somebody could interpret it like that. But in the realm of the Medicare field of expenses, private coverage has provided catastrophic coverage to 70 percent, 12 percent are covered by Medicaid, about half of the remaining would be covered under Medicaid under Bowen's proposal because they have to spend $2,000 to get to the catastrophic that Bowen proposes, and by that time they would be in Medicaid anyway—so why spend money under Bowen's proposal to get Medicaid when they would just get the Medicaid anyway? And Bowen says that the remaining, the other people who do not have any coverage, who are another few percent, could buy his coverage. Well, they can buy coverage from us, too.

Senator PRESSLER. Let me ask one final question, Mr. Chairman, and then I may have some for the record. I am trying to thoroughly understand this.

On page 4 you state, "For the working population, studies of group employee benefit plans among commercial health insurance companies have shown trends toward adoption of plan features that will both help contain costs and improve the comprehensiveness of the plans." Then you say, "A higher percentage of employees today than ever before have larger maximum benefit levels, with nearly 80 percent having maximum benefits of $1 million or more."

Now, what does that mean, that 80 percent that have maximum benefits of $1 million, so they can get coverage——

Mr. SHAPLAND. We are saying that those employers that have bought group insurance for their employees, that 80 percent have full catastrophic coverage.

Senator PRESSLER. Those companies that have coverage for their employees.

Mr. SHAPLAND. Right, those that have chosen to buy group insurance for their employees.

Senator PRESSLER. And of course, there are a lot of people—what percentage of Americans is that?

Mr. SHAPLAND. I am sorry, but I do not have that number.

Senator PRESSLER. OK. It is probably what, 20 percent maybe?

Mr. SHAPLAND. Oh, no. We are talking about the vast majority of the employees. Where you do not have group insurance is where you have employees with minimum wages, and the employers just do not have the money to buy group insurance.

Senator PRESSLER. What percentage of the people would that be? Who would that be?

Mr. SHAPLAND. I do not know. Maybe 10 percent. I am just guessing now.

Senator PRESSLER. Can we get that for the record? Somebody is just now providing that to you. What percentage is it?

Mr. SHAPLAND. I have just gotten a note that says there are 240 million who are, I guess, employees, and 172 million have group insurance—if I understand this note correctly.

Senator PRESSLER. So it would be less than 50 percent, then, is that right?

Mr. SHAPLAND. Oh, no. There are 240 million Americans, and 172 million have insurance. The vast majority of that would be group insurance.

Senator PRESSLER. There are how many million Americans?

Mr. SHAPLAND. This says there are 240 million Americans, and 172 million have insurance.

Senator PRESSLER. Of $1 million or more?

Mr. SHAPLAND. No. It would be just how many have insurance, I think.

Senator PRESSLER. OK.

Mr. SHAPLAND. But 80 percent of the 172 million would have $1 million or more. The insurance industry tries to sell catastrophic coverage, but some employers just do not have the financial means. They are working with minimum wage employees with high turnover, and they just are not going to come up with the money to have a group insurance program.

Senator PRESSLER. Well, I thank you. I am going to have some more questions on some of these statistics. I think some of us who are trying to make these decisions have to understand this. It is terribly complicated. But somehow, some Americans are being left out. We heard from some of them today who are very hard-working middle-class people. As I go about my State, as I am about to begin to start a new project this year of visiting every county, I bet I will hear from someone who would like to have private health insurance, but who cannot get it for one reason or another. There will be somebody else who thought they had some kind of insurance, and they did not. Really, I guess that cannot all be thought to be your fault. Individuals have some responsibility, too, to inform themselves, and we cannot just expect people not to take some responsibility of their own.

But there are people who slip through the slats, and we do have a problem out there.

Mr. SHAPLAND. I might comment on one of the things you said about people who have a heart condition who cannot buy insurance because they are uninsurable. The Health Insurance Association has been very active for quite a few years, trying to get Congress to pass a law that supports State uninsurable risk pools. There are already at least 10 States that have such pools, so that those people do not fall through the cracks. And we ask you to support that legislation.

Senator PRESSLER. Thank you very much.

Chairman MELCHER. Senator Wilson.

Senator WILSON. Thank you, Mr. Chairman.

First of all, I do not want to dwell on this at great length, because there are many other questions I want to ask you, but why is that legislation necessary? Why can't the organizations do that voluntarily?

Mr. SHAPLAND. The States pass laws, these uninsurable risk pool laws?

Senator WILSON. Yes.

Mr. SHAPLAND. They can. We are asking for a law to be passed that allows what we call a fair distribution of the losses of those pools. Right now, the law precludes self-insurers from being charged for their fair share of those losses. We think there should

be a fair distribution of the losses of those pools. That would require an act of Congress to change that.

Senator WILSON. OK. I gather from the comments you have made that you and your industry are not a supporter of the Bowen proposal and that you feel that insofar as it supplements existing gaps in Medicare, that it is not going to do the job, and yet I understood—perhaps this is your personal view that you were expressing earlier—you said there is need for some tax dollars to be spent to take care of people who have problems of the kinds we heard described this morning.

Is it your industry position that more coverage needs to be afforded by additional Medigap coverage from the private sector?

Mr. SHAPLAND. Let me first of all correct a possible misunderstanding about Bowen and the health insurance industry's position.

Bowen has many proposals. He had one on expanding Medigap. We say that is unnecessary because the people already have the coverage, and he is only making it available on an optional basis, and whoever wanted to buy insurance has already bought it so it is not going to do anything; it is not attacking the real areas of need—long-term care, drug care, and so on. His proposal does not hit that. And that is why we say that that proposal is not a very good one.

But Bowen has many other proposals to fill gaps—employers who cannot afford group insurance on their own without some help; lower-income people who cannot afford the full cost of insurance, and so on.

Senator WILSON. And who do not qualify for Medicaid, either?

Mr. SHAPLAND. Right; they fall between being able to buy private insurance and Medicaid. And those things, we support; I mean, he is on target, that where people cannot afford to buy private insurance, maybe the Government needs to help subsidize insurance, subsidize long-term care insurance and so on to cover that missing ground, some of those loopholes.

Senator WILSON. All right. On page 3 of your statement you have indicated that some 70 percent of Medicare beneficiaries use private supplemental insurance; that another 10 percent of the remaining uncovered 30 actually fall under Medicaid. So that leaves only 20 percent of those over 65 without protection against gaps in Medicare.

Mr. SHAPLAND. Right.

Senator WILSON. What I think I heard you saying is that the industry supports the provision of long-term care and is looking to the private sector to provide that care.

Mr. SHAPLAND. The long-term care has nothing to do with what you just mentioned. It has nothing to do with Baucus or Medicare or Medigap. It is a completely different area of insurance. I just want to make sure you understand that.

Senator WILSON. All right. Let us focus on the long-term care. How does the industry see that need being filled?

Mr. SHAPLAND. OK. We see, as I think almost everybody sees—and I do not know if there is much disagreement on this, even in discussions privately with various Congressmen and so on—the cost of providing needed coverage for long-term care is almost beyond

comprehension, and it is growing because of the aging of our population. It is going to be a very, very difficult solution.

We see that it is going to call for private insurance to the extent that people can buy private insurance; the Government stepping in to fill voids where people cannot afford private insurance. The Government may be helping pay premiums to some degree for some people who cannot afford the full cost of private insurance. There is a whole gamut of solutions.

I sort of feel sorry for you to some degree, knowing the financial crunch that the Government is under at this point, and knowing that there is this crying need out there, because it is a terrible conflict that I am glad you are facing and I am not.

But to the extent that the insurance industry can sell private insurance to those who can afford it, then that is the way to solve that; let the people who can take care of themselves take care of themselves, the people who cannot, the Government should help.

Senator WILSON. Well, let me ask you this question. Is there a market for private health insurance to deal with long-term care? There is obviously a small market today, and I guess we would all agree that the problem is that the premiums make it unaffordable to a great many people who would otherwise be interested.

Mr. SHAPLAND. I think the studies have shown that maybe the vast majority can afford the premiums——

Senator WILSON. The vast majority can afford?

Mr. SHAPLAND. Can afford the premiums.

Senator WILSON. Well, then, why in the hell don't they buy it—excuse me.

Mr. SHAPLAND. It is because long-term care is in its infancy. The insurance industry is just coming of age in offering this coverage. That is why not too many people have it.

We have held, in conjunction with HCFA and other parties, all kinds of seminars educating ourselves on the need for long-term care insurance, and there is just a raft of companies now starting to offer long-term care. So it is just coming of age. I think you have to give us a chance to sell this insurance.

We have mentioned that one hindrance was that 80 percent of the people think they do not even need to buy it.

Senator WILSON. What was that? I am having a little trouble hearing you, Mr. Shapland.

Mr. SHAPLAND. We have already talked about the fact that 80 percent of the people think they do not need to buy long-term care insurance because of Medicare.

Senator WILSON. OK, that is the education problem, and I agree with the points that you made that the Federal Government ought to be doing a much better job about educating.

Mr. SHAPLAND. Right.

Senator WILSON. Incidentally, I do not think that is beyond the realm of possibility. The problem is one that does exist, and I can think of all kinds of networks for communicating with the elderly. The problem is that the people we need to communicate with are the middle-aged.

Mr. SHAPLAND. Well, both.

Senator WILSON. Well, all right, I agree, both. But I can think of all kinds of means of communicating with an audience that is a

little bit past the age where we are seeking to interest them in taking advantage of what may be offered.

But the basic point, I think, is less one of education than of the affordability. So let us come back to that.

Mr. SHAPLAND. Affordability. OK.

Senator WILSON. You say that the industry is in its infancy in addressing this problem. I guess the question is you have got something of a chicken-and-egg situation in that it would appear that were it more affordable, there would be a much larger market. Possibly, if there were a much larger market, it would be more affordable.

Now, one of the basic questions facing this committee and this Congress, it seems to me, is to whatever extent we move in the area of expanding health care coverage, we have got what you describe as many options—at least two that I see. One is for the taxpayers to pay it in terms of a direct subsidy. The other is to pay for it in what is termed a tax expenditure. By that, I mean what it will cost the Federal Government by way of lost revenues if we give, let us say, an individual policyholder a tax deduction for premiums paid for that kind of extended health care coverage.

I assume that the industry has a position as to which of these two options is preferable.

Mr. SHAPLAND. I am sorry, I cannot remember what the first option was that you mentioned.

Senator WILSON. Well, it is direct subsidy by taxpayers, or indirect by a tax deduction.

Mr. SHAPLAND. Well, there are lots of ways to subsidize. You can have direct vouchers to help pay premiums. You can have it tax-deductible as an itemized expense, and so on. I think that no matter how you do it, the Government has to ask itself whether it has any money to do anything. And then the second question is if it does spend some money, is it really seed money that is going to return many-fold, because if you get, with a little bit of help, people to buy long-term care insurance, that could save—who knows—10, 20, 30 times as much money down the road in Medicaid, because people would be funding this thing out of their own pockets with a little bit of encouragement from the Government, dollar-wise, and then they would not be on Medicaid when they do go on long-term care, and that saves Medicaid dollars.

I do not know how you make the calculations of how much you would get back for that seed money, but that is one of the questions I think you need to wrestle with.

Senator WILSON. What is the industry doing, or at least the members of the industry who are members of your association, to address this question? Are any of your members now providing long-term care to any significant audience?

Mr. SHAPLAND. We are offering long-term care insurance to anybody who will buy it. The Health Insurance Association itself has had many educational meetings for its members, trying to point out that, gee, you guys ought to get into this market because it is a terrific market, because everybody needs insurance, so obviously, any time there is a need, there is a market. And the insurance companies have gone through an educational process. As I said, it is a fairly new market for us to be in, and we have gone through

that educational process, and we are all coming out with policies, and we are going to be actively marketing.

I can talk about my own company. We have had a nursing home care policy, and I am on a committee that has just developed what I would say is probably one of the best policies in the industry that we are going to be releasing very shortly. And we are going to spend a lot of money trying to promote it and sell it.

Senator WILSON. Well, isn't it true that to the extent that you and some of your competitors actually develop a competition that you are going to wind up offering better benefits at better premiums? Isn't that the history of competition in your industry?

Mr. SHAPLAND. Sure, that is the reason we have the free enterprise system here in the United States. The same thing happens in the insurance industry as anywhere else. I mean, you have low auto insurance rates because you have competition. You can have low nursing home rates because you have competition, but only as low as what the claim experience says they can be. There is an irreducible minimum.

Senator WILSON. Let me ask you a question that assumes that the industry is going to want to expand coverage and expand the competition—otherwise I might point out this is all mostly academic.

Mr. SHAPLAND. No. I can assure you that it is definitely committed to that, and the events of the last year aptly demonstrate that. There are just a myriad of companies that are introducing nursing home policies. We are not just sitting still.

A year ago, I might have said there are only a few companies out there selling nursing home policies, and today there might be 70, and maybe tomorrow or a year from now, there will be 200.

Senator WILSON. Could you provide the committee with some statistics as to what actually has happened in this last dramatic year, because I——

Mr. SHAPLAND. We would have to run a new survey. But I could easily give you some survey information from our prepared statement.

Senator WILSON. There must be some survey information in there. What I would like to receive as well would relate to the kind of coverage that is being offered.

Mr. SHAPLAND. Yes. Let me offer this and see if it would fill your needs. I could send you information regarding, say, 20 random nursing home policies and exactly what they pay, to give you an idea of what nursing home coverage out there is like. That would be a very easy thing for me to do.

Is that what you are looking for, trying to find out what coverage is being offered?

Senator WILSON. I am trying to find out what coverage is being offered and also what the real interest is, and that is perhaps the best way to determine it, of the industry in getting into the field and creating a competition that does not seem to yet exist.

Mr. SHAPLAND. The last part, I am having trouble rationalizing in my own mind how I would answer or provide you with information, because——

Senator WILSON. Well, just provide me with the information as to what policies are being offered by what companies outside of the current coverage, that relate to——

Mr. SHAPLAND. I can give you a list of all the companies that we know about and their policies.[2]

Senator WILSON. That would do it.

Let me ask you this now. Assuming that there is a desire on the part of the industry to move aggressively into the field, or assume that they are undecided, which I take to be an understandable position, that they are not quite sure what to do and how to go about it, there is already, in anticipation of a decision to become more involved, some concern that has been expressed on the part of those who are interested from the standpoint of consumer protection—I do not know whether Ms. Shearer is here this morning, but I have got a statement from her. She represents the Consumer Union and has expressed a great deal of concern about deceptive and fraudulent marketing.

And of particular interest to me, as you might imagine, is a reference to a petition by the Consumers Union to the insurance commissioner of the State of California, in which they have urged a halt to what they term unfair and deceptive marketing of Medigap insurance to senior citizens. Their petition claimed that unscrupulous agents in California had loaded up senior citizens with overlapping policies, caused seniors to cancel policies and replace them with new ones, creating lags in coverage, had misrepresented themselves as being from Government agencies or independent senior organizations, and had exaggerated the coverage offered by policies and failed to disclose the substantial limits and exceptions to coverage.

You have said that the Association provides would-be policy-holders with a buyers' guide.[3] Could you provide a copy of that buyers' guide to the committee; and could you respond what steps does your Association take to police itself or to police the industry? It may be that your members deplore the kind of practices that are complained of here as much or more than those who are in the business of consumer protection—and I suspect that that is certainly true of many of your members.

What efforts are made, what steps are taken, to guard against this kind of deceptive and fraudulent marketing? I will just leave the question there. I can think of steps that I assume you are already taking.

Mr. SHAPLAND. OK. I am glad you asked the question. Quite a few years back, there was abuse of the aged public by salesmen selling duplicate policies and so on. And there was an outcry that we reacted to—in fact, before almost anything happened, the Health Insurance Association wrote a letter to almost every company asking them to clean up their act.

But we did a lot more than that. We went out and sought legislation at the State level to prohibit that kind of action, and that legislation was passed by all the States.

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[2] See appendix, item 8, p. 180.
[3] Ibid., p. 191.

So we have supported and actively promoted and gotten going regulations which prohibit unfair sales practices and so on and require, as I mentioned quite earlier in the hearing here, that everyone be given a buyers' guide and that everyone be given an outline of coverage, both of which tell what the benefits are and what they are not.

When you get down to replacement, there are legal requirements that we supported that say if you replace somebody's policy, you have got to give them this form that warns them about doing such a thing. So if somebody out in California is breaking those laws and rules, we say prosecute them. We want them prosecuted. If somebody is not abiding by the rules and playing fair, then there are all kinds of laws out there to enforce them.

We asked them to be passed, they were passed—now, enforce them.

Senator WILSON. All right. That is fair enough.

Well, Mr. Chairman, you have been more than generous, and I am grateful. I can tell that once you were a junior member of a committee as well.

Chairman MELCHER. Thank you, Senator Wilson.

Mr. Shapland, first of all on this question of notification of people on Medicare and what Medicare covers and what it does not cover, I believe this committee will endeavor to work out with HHS a notification to each and every person who is not only now on Medicare, but who will be eligible for Medicare in the next 2 or 3 years—a notification of exactly what it does, in language that can be easily understood.

I think it is ridiculous that we have had Medicare for, what is it—20 years—we do change the law from time to time, but nevertheless it is our obligation here in Congress as well as the executive branch of Government to make sure that people understand what they are buying when they get Medicare. All of us are buying it when we contribute to the Medicare Trust Fund, and it is a blot on our record that we have not made clear exactly what it does.

Now, on this question of you not knowing what it costs for everybody to be covered for long-term health care, nursing home, or a combination of nursing home and health care at home, you are an actuary, Mr. Shapland, and I suspect one of the leading actuaries of Mutual of Omaha, is that correct?

Mr. SHAPLAND. I would like to think so.

Chairman MELCHER. Well, why don't we start from where we are at? Everybody—everybody—who is impoverished is going to get long-term health care no matter what it costs.

Mr. SHAPLAND. They already do through the Medicaid Program, that is right. But there are some loopholes that I think we have discussed in the Medicaid Program.

Chairman MELCHER. No, we have not discussed loopholes. We have discussed the fact that we hate to be impoverished as individuals. That is normal, that is natural. That is the way we are built. That is the way the human body is and the human brain is and the human intellect is, and that is the way our society is.

What we are really after is how to preserve some dignity and integrity in people's lifes—in other words, not be flat broke—and know that if you have to be incapacitated or debilitated in a nurs-

ing home, or a hospital, or at home with extra care—that you can do so with dignity. We want to step up and make it possible for people not to be flat broke in order to be certain that they are going to have that kind of help.

Can you provide for the committee, on the basis of actuarial calculations, at some threshold what it would cost—not necessarily Bowen's $2,000, which is a small threshold—but at some threshold where Americans could be assured that they get this catastrophic protection in nursing homes or at home and what it might cost; because that is exactly what the voters and the taxpayers want to know when we have a bill on the Floor. Additionally, what are we going to have to know if we expect to pass a bill—and we do expect to pass some type of bill.

Mr. SHAPLAND. Let me make sure I respond to your request. I want to respond to your request, so I have to make sure I understand it.

There are lots of figures available on what the current expenditure for nursing home care cost is; how much of that is being paid for by Medicare and Medicaid and how much is being paid out of people's own pockets. If that is the kind of number you are looking for, how many billions of dollars people are having to put out of their own pockets for nursing home costs today, I can give you that figure real easily, and how much of that is being paid for by Medicaid and so on.

Is that what you are looking for?

Chairman MELCHER. Let us put the second part in. There is the threshold where somebody such as Mrs. Fish's mother has utilized $10,000 of her savings—the mother's savings—and at that point, either the nursing home or the home health care assistance is going to be covered.

Mr. SHAPLAND. I would like to make a suggestion. Insurance companies do not have those kinds of numbers.

Chairman MELCHER. Well, now, wait a minute.

Mr. SHAPLAND. But somebody does that you can obtain them from and that is the Health Care Financing Administration.

Chairman MELCHER. Well, you can generate them, can't you?

Mr. SHAPLAND. No. You are talking about Government figures.

Chairman MELCHER. How can Mutual of Omaha offer a good insurance plan that I can buy for so much a month that is going to keep me whole if I have to go into a nursing home—you have some figures on that, or you would not have a basis for charging, what the policy costs.

Mr. SHAPLAND. But I thought the question had to do with people's incomes.

Chairman MELCHER. No, not people's incomes.

Mr. SHAPLAND. I thought you said how much would it cost on a spend down basis.

Chairman MELCHER. A threshold of $10,000 being spent. The Bowen proposal says spend $2,000, and we are going to pick up some extra protection for you. I am saying spend some figure—I do not care what figure you use, because it does not make any difference whether it is $7,000, $8,000, $5,000, $10,000.

Mr. SHAPLAND. How much would nursing home insurance cost if we provided it to everybody in the United States after they had spent their first $10,000, or whatever?

Chairman MELCHER. Right, exactly.

Mr. SHAPLAND. Well, what I am saying is the insurance industry just sells insurance policies. It does not have any information about the income of those people or how much they would have spent down to get to a nursing home. But there is a source of that kind of information.

The Federal Government made a study some years ago and is just now completing another one of the demographics involved with nursing home care. So I think if you go to HCFA, they are the ones that are equipped to answer that question.

Chairman MELCHER. I am asking you, though. Whatever HCFA has got, you can get. I am asking you.

Mr. SHAPLAND. I can get it from HCFA if you would like me to. Is that what you want me to do?

Chairman MELCHER. No. I want you to take it. All you are telling me so far is that you do not know how many people could afford to spend $10,000.

Mr. SHAPLAND. No, I do not know how many people have $10,000, or how many can afford to spend $10,000.

Chairman MELCHER. No, I know you do not.

Mr. SHAPLAND. Yes, we can get that information. We would go to HCFA to get that information.

Chairman MELCHER. Yes, you will go to HCFA, which I can, but what I am asking you is to use whatever information HCFA has and then, through your experience as an actuary, tell us what we might expect for that to be in terms of cost.

Mr. SHAPLAND. I want to respond. I am offering my services, and we will go to HCFA and get any information you want. I want to make sure I understand what you are asking. I can either spend a few seconds here, talking with you some more, or work with your staff on it. But if you are asking how much it would cost to provide nursing home coverage to the population of the United States over 65 after they spend down so many dollars out of their own pockets—is that what you are asking?

Chairman MELCHER. Exactly.

Mr. SHAPLAND. We will work with HCFA and try to get you that information.

Chairman MELCHER. All right. Now, let me get at why I am asking you this. Basically, it is because I am sure you would agree with me that the best money we spend in medicine is preventive medicine; and second, that the second-best dollar we spend in medicine is on timely treatment. Isn't that correct?

Mr. SHAPLAND. Yes.

Chairman MELCHER. And the reason that is the second-best dollar we spend after preventive medicine is because timely treatment will actually cut down the costs for an individual.

Mr. SHAPLAND. There is even a higher priority than both of those.

Chairman MELCHER. What is that?

Mr. SHAPLAND. That is what I call "wellness" which may be what you are thinking about in preventive treatment. There have

been quite a few articles that have said—and I do not know how they come up with the numbers—but they say that 70 percent of the health care costs in the United States are because people abuse their bodies and bring these costs on themselves. So, by getting people involved in taking care of themselves, you will not have the health care in the first place.

Chairman MELCHER. Well, I have given up telling my wife it would be better if she did not smoke, and telling the kids to forget about so much alcohol.

Mr. SHAPLAND. But there are incentives. I am sort of a nut on this subject because I feel very strongly that we should have financial incentives wellness.

Chairman MELCHER. Well, what I am getting at is one of the witnesses today graphically demonstrated that because her husband had piled up bills for his health care that she could not handle, that she was foregoing treatment for her high blood pressure and some corrective knee surgery.

I do not know what that is going to cost in the long run, but it might cost a ton of money.

Also, Mrs. Yelineck, for reasons I understand, put off surgery she needed, which was not wise.

Mr. SHAPLAND. Correct.

Chairman MELCHER. Now, I am not going to ask you to do this, because I think it is too tough to figure out. But when we remove those obstacles—in this case, for these two witnesses, just to do what they ought to do, in a timely way—we are cutting down on the costs of medicine for them throughout their lives.

Now, obviously, that is a savings, it is an offset. I am not going to ask you to measure that. I think that is very difficult. The first one, I do ask you to measure—if at some threshold, each individual in America would be spending so much for either nursing home or home health care, what it would cost.

Mr. SHAPLAND. You see, the insurance industry wrestles with this problem every day and has modernized its coverages over the years for this very reason. For example, we ask ourselves if we provide home health care, isn't that a lot cheaper and better for everybody. For every dollar one spends on home health care, maybe they save $10 in nursing home costs.

So to the degree that, say, Medicaid does not cover some of those things, I think you need to think about expanding Medicaid so that it does. Penny-wise and pound-foolish is what you are talking about.

Chairman MELCHER. Yes, that is exactly what I am talking about. Now, I have asked you for three things—first, this actuarial advice to us, and then for the critique on the Harvard Medicare study—and what was the other one of those?

Mr. SHAPLAND. I have down here that you have asked me to provide you with the new NAIC standards on long-term care; [4] to read the Harvard report and give you my analysis of that; [5] to give you a list of the companies and policies that provide long-term care cur-

[4] See appendix, item 8, p. 153.
[5] Ibid., p. 150.

rently being offered by the industry; [6] to provide the buyers' guide on Medicare; [7] and to provide you with some information about the spend-down on long-term care and what the cost would be.[8]

Chairman MELCHER. That is correct. You included what Senator Wilson had asked for, too, and that is fine. Thank you very much.

Mr. SHAPLAND. You are welcome.

Chairman MELCHER. The committee is adjourned.

[Whereupon, at 2 p.m., the committee was adjourned.]

[6] See appendix, item 8, p. 180.
[7] Ibid., p. 191.
[8] Ibid., p. 151.

APPENDIX

MATERIAL RELATED TO HEARING

Item 1

TESTIMONY OF MRS. MARIANNE COSTLOW
Before the Special Committee on Aging
United States Senate
January 26, 1986

My name is Marianne Costlow. I live with my husband, daughter, and son, in St. Michael, Pennsylvania. I am testifying on behalf of my daughter, Karri Lynn Naugle, who has been in a coma for the last five and-a-half years.

In 1981, Karri Lynn was employed as a security guard at Bethlehem Steel. On June 27 of that year, Karri was involved in a serious motorcycle accident which caused severe internal trauma to her brain and left her in a coma. Karri was 31 years old at the time. Her chance of survival, on a scale of one to one-hundred, was a two. She was in intensive care at Lee Hospital in Johnstown for 6 months and in a skilled nursing facility for another 6 months.

Karri's hospital bills for that year totalled $125,000. Her doctor's bills alone came to about $10,000 dollars. Karri was insured by Blue Cross major medical through Bethlehem Steel. This covered the $125,000 in hospital bills. But, since Karri was injured on a motorcycle, the insurance did not provide lifetime coverage.

Karri has been receiving $627 dollars a month in Social Security Disability benefits, and qualified for Medicare two years after her accident. But Medicare has not covered all of Karri's medical bills. As a result, all that is left of the $70,000 dollars which Karri received from the drivers of the car and motorcycle as settlement from the accident, is $1,500 dollars.

Recently, Karri Lynn has started to come out of her coma. When she was examined by a doctor at Harmarville Rehabilitation Center in Pittsburgh, in November of 1985, he said that it was imperative that Karri receive coma therapy immediately for her to regain any normal mental functioning. I was told by Medicare, however, that this therapy would not be covered because Karri did not enter therapy immediately after she left the hospital. The therapy would cost $8,000 a month or $200 dollars a day. We don't have the money to pay for this.

On top of Karri's problems, my husband suffered a heart attack 2 years after her accident. He has not been able to work since then. He receives $612 a month in Social Security disability insurance and $312 a month in pension benefits from Bethlehem Steel. He worked for Bethlehem Steel for 21 years.

He is a Korean War Veteran, and was a prisoner of war for 33 months. Karri Lynn's brother was injured in an accident soon after Karri was injured. As a result, he needed medical care for 1 year, compiling medical bills of $9752. Fortunately, this was paid for by welfare. Since Karri Lynn has required constant attention since her accident, and we can't afford a live-in nurse, I have been unable to work. Karri Lynn is, however, being seen once a week by a skilled nurse.

I would like to thank you for allowing me to tell you Karri Lynn's story. I just want to add that there are alot of people in this country who are suffering through a situation very similar to Karri's. It is comforting to see that the federal government is finally taking an interst in our problems.

Item 2

TESTIMONY
OF THE
BLUE CROSS AND BLUE SHIELD ASSOCIATION

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ON

COVERAGE OF THE ELDERLY'S CATASTROPHIC HEALTH CARE EXPENSES

PRESENTED BY

MARY NELL LEHNHARD
VICE PRESIDENT

JANUARY 26, 1987

Mr. Chairman and Members of the Committee, I am Mary Nell Lehnhard, Vice President of the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield Association, representing 78 Blue Cross and Blue Shield Plans, is pleased to comment on the need for catastrophic coverage for the elderly. The Blue Cross and Blue Shield Association and its Member Plans have been major participants in Medicare since its beginning. Blue Cross and Blue Shield Plans also underwrite benefits to supplement Medicare coverage for about nine and one-half million beneficiaries, approximately 45 percent of all beneficiaries who purchase Medigap coverage.

We applaud your concern about protecting the elderly from financially catastrophic health costs. The elderly may incur catastrophic costs for acute health services not covered by Medicare or for cost-sharing involving Medicare-covered care. In this regard, we would like to comment on HHS Secretary Bowen's recent proposal, and S. 210, the bill you are co-sponsoring with Senator Kennedy. Your bill would establish a new government program of acute care expense protection available to all elderly and disabled persons, and is based on Secretary Bowen's recent recommendations.

We also would like to comment briefly on catastrophic expenses for long term care. These expenses threaten the finances of more elderly than do acute-care expenses. We will address the need for private long term care insurance, because Medicare does not cover expenses for long term care.

The Melcher-Kennedy bill, S. 210, would:

- o Establish a new federal program of health expense coverage available to persons who have attained age 65 or are disabled.
- o Limit out-of-pocket expenses for Medicare deductibles and coinsurance to $2,000 annually.

- o Eliminate Part A coinsurance and lifetime limits.
- o Limit the Part A deductible to two per year.
- o Finance these changes with "self supporting" premiums deposited in a new earmarked Trust Fund.
- o Index both this premium and the annual liability cap to future cost increases.

This proposal is identical to HHS Secretary Bowen's proposal except that the S. 210 program would be authorized as a "freestanding" program under the Public Health Service Act, rather than as an integral feature of Medicare Part B. Therefore, enrollment in the S. 210 program would be entirely voluntary, in contrast to Secretary Bowen's proposal to tie continued eligibility for the current Part B program to payment of the new premium for catastrophic coverage.

Private Insurance Protects Most Elderly from Acute-Care Catastrophic Expense

We believe that the private market has functioned well in providing protection against major financial loss for acute-care expenses of the majority of Medicare beneficiaries. Most Medicare beneficiaries are protected against excessive out-of-pocket costs for hospital and physician care by private coverage which supplements Medicare benefits — Medigap. Overall, 72 percent of the elderly supplement Medicare with private coverage, according to the Congressional Budget Office. About half of this supplemental coverage is provided on a group basis - mainly through retirees' former employers - and about half is purchased individually.

We believe the private Medigap market has functioned well to protect the majority of the Medicare population from excessive financial liability. An amendment to the Social Security Act in 1980, often referred to as the Baucus Amendment, established minimum

standards for voluntary certification of Medigap policies. Forty-six states have enacted statutes adopting the Baucus Amendment and, thereby, require that certified Medigap programs cover all Medicare hospital coinsurance. Approved programs also must cover at least 90 percent of the cost of at least 365 days of acute hospitalization after Medicare benefits have been exhausted. Medigap policies also must cover at least $5,000 annually in Part B cost-sharing liability, once a $200 deductible is paid. The four states that have not enacted standards pursuant to the Baucus Amendment have adopted their own standards that differ only slightly from the model established by the Baucus provision.

We would point out that the Baucus Amendment requires a more comprehensive — and therefore a more expensive — level of protection than that recently proposed by HHS Secretary Bowen. In addition, most Medigap subscribers have coverage that exceeds standards under the Baucus Amendment.

Blue Cross and Blue Shield Plan Medicare supplemental programs meet or exceed applicable requirements, as confirmed by recent studies of the U.S. General Accounting Office (GAO) and the House Aging Subcommittee on Health. The GAO study also reviewed loss ratios from a sample of Blue Cross/Blue Shield and commercial policies, and concluded the the Blue Cross/Blue Shield products had a substantially higher aggregate loss ratio than did the commercial products.

Moreover, when we review all Blue Cross and Blue Shield Plans' Medigap products, we find loss ratios higher than those calculated by GAO in its sample of Plans. The Blue Cross and Blue Shield organization's aggregate 1979-1984 loss ratio on Medicare supplemental products was 90.8 percent, and many Plans incurred annual loss ratios

exceeding 100 percent. Thus, we believe that Medigap products offered by Blue Cross and Blue Shield Plans provide good value to elderly consumers.

A major advantage of the private market is that it allows beneficiaries to select among hundreds of products to obtain a policy tailored to their needs. Consumers can choose policies that meet or exceed the Baucus requirements, plus benefits such as prescription drugs, vision and hearing care, and convalescent assistance at home — benefits that neither the Medicare program nor the proposed federal catastrophic program for the elderly would cover.

Blue Cross and Blue Shield Plan Medigap products offer substantial choices for coverage of expenses that are neither covered by Medicare nor required under the Baucus Medigap standards. In 1985, for non-group products we estimate that 88 percent of Plan products covered Part B expenses beyond the $5,000 minimum required under the Baucus Amendment, 84 percent of products covered each hospital deductible, 86 percent covered Skilled Nursing Facility copayments and 63 percent covered the $75 Part B deductible. In addition, 43 percent of Plan products offered coverage for prescription drugs, 36 percent covered Skilled Nursing Facility days after expiration of Medicare benefits, and 29 percent offered vision care coverage. Several products also provide benefits such as wellness education, psychiatric benefits beyond Medicare, and convalescent homemaker services.

While such comprehensive coverage is preferred by most Medigap buyers, many Blue Cross and Blue Shield Plans also offer less extensive and less costly coverage. This variety of coverage options is reflected in Plans' Medigap premiums, which ranged from $18.13 to $130.00 per month for non-group products in 1985. Ten percent of all

non-group subscribers of reporting Plans paid $20 or less per month, 40 percent paid $30 or less and 75 percent paid under $43. Blue Cross and Blue Shield Medigap coverage is available in every state.

The Major Catastrophic Acute Care Coverage Gap: Low-Income Elderly without Supplemental Coverage

While we believe that the Medigap programs offered by Blue Cross and Blue Plans represent a "good buy" for most beneficiaries, there are those who cannot afford any private coverage that meets the minimum standards of the Baucus Amendment. According to a study funded by the Health Care Financing Administration, about half of the beneficiaries without supplemental protection said they simply could not afford it.

This finding is confirmed by a Congressional Budget Office (CBO) analysis showing that low-income beneficiaries are the ones most likely to lack supplemental coverage. According to CBO, nearly 30 percent of the elderly with incomes under $9,000 lack both Medigap and Medicaid, versus only 10 percent of those above $25,000. CBO also found that Medicaid covers only 28 percent of the elderly with incomes under $5,000.

Thus the major issue facing Congress is not a problem of coverage availability but of affordability to those with limited resources. Accordingly, we believe any new government program should be targeted to those who cannot afford existing private coverage, and will suggest a number of options to accomplish this. We also believe that the availability of government coverage — whether voluntary or mandatory — will not solve the affordability problem. Comprehensive coverage is not inexpensive, whether provided by government or the private sector. Conversely, providing only a minimum level of catastrophic protection still would leave the low-income elderly exposed to substantial out-of-pocket expenses.

Unfortunately, under a non-subsidized federal program, the cost of even a minimal level of coverage could place a burden on the low-income elderly. For example, our actuaries project the benefit costs alone under the Bowen proposal to be $7.33 per month - $87.96 annually - while HHS estimates the premium at $4.92 per month. Even assuming HHS's estimate of a $4.92 monthly premium for 1987 is accurate, this amount would not be affordable to many lower-income beneficiaries. For example, beneficiaries entitled to the average Social Security monthly cash benefit are receiving a 1987 cost of living adjustment of $6.00 per month. The new $4.92 monthly premium plus the 1987 increase of $2.20 in the Part B premium thus would exceed the average cost of living adjustment. Beneficiaries could face additional financial problems under the Administration's proposed increase in the basic Part B premium.

Finally, we are also concerned that a new federal program could give many low-income beneficiaries a false sense of security but still leave major gaps. Its "catastrophic" benefit would not cover the first two hospital deductibles or other liability approaching $2,000 annually, nor beneficiaries' "balance billing" liability on unassigned claims, nor acute care not covered by Medicare, such as prescription drugs, hearing and vision services. Many Medigap products cover most or all of these expenses. That is why Medigap premiums tend to be higher than the $4.92 monthly premium proposed by Secretary Bowen.

These uncovered costs can be catastrophic for low-income beneficiaries. While we recognize and support the fact that S. 210 would leave coverage of these expenses to the private sector, many elderly persons may not purchase needed additional private coverage based on the mistaken belief that the new federal program would provide full catastrophic protection.

We believe a new federal program could be particularly problematic if it were mandatory. A voluntary program such as S. 210 assures that no low-income beneficiaries would be forced to drop their Part B coverage in order to afford the cost of "catastrophic" coverage. However, the voluntary nature of the program proposed by S. 210 could increase expenses through "adverse selection." That is, persons who expected to need "catastrophic" protection might enroll disproportionately.

On the other hand, from our perspective, a voluntary program, such as embodied in S. 210, is preferable to a mandatory one. A voluntary government program does permit the elderly to choose between governmental and private sector products.

In summary, because the private market is working well, we believe that the government's role should be limited to a residual one for those for whom private coverage is not affordable.

Alternatives to a New Federal Program

Congress could consider several alternatives to a new federal program. We would urge to you consider expanding Medicaid eligibility; providing lower-income beneficiaries with greater purchasing power in the private market through subsidies or other mechanisms; and providing for the expansion, promotion and adequate payment of alternative health plans for Medicare beneficiaries.

In addition, we recommend increased beneficiary education on the limitations of current Medicare benefits and on additional benefits available through private Medigap plans. Expanded beneficiary education could increase knowledge of Medicare's coverage limits. A major study by Rice and McCall found beneficiaries' belief that

"Medicare will cover everything" was the second most frequent reason why they do not buy Medigap. State agencies in Washington, Wisconsin and Idaho already are operating successful education programs and other states are considering this approach. The Department of Health and Human Services could provide information to newly enrolled Medicare beneficiaries, including comparisons of coverage, loss ratios, and exclusions of private plans that meet the applicable state and federal standards. In addition, beneficiary education could emphasize that neither Medicare nor Medigap are designed to cover long term care.

Alternately, senior groups or Medicare contractors could provide educational outreach. These programs could inform beneficiaries about existing options to minimize their expenses, such as HMOs/CMPs, and could help beneficiaries compare the value of Medigap policies. Secretary Bowen's report recommends education for long term care, but that also would be a relatively inexpensive approach to inform beneficiaries of the need for catastrophic coverage of acute-care expenses.

Long Term Care Catastrophic Protection

The lack of long term care protection is the largest catastrophic coverage gap for the elderly. While Medicare and Medigap provide the elderly with reasonable protection from catastrophic acute-care expenses, long term care is the elderly's largest single out-of-pocket health expense.

The private sector is beginning to respond to this need. The Blue Cross and Blue Shield organization recently completed a major effort to determine the feasibility of long term care insurance. Though multiple impediments exist, we believe insurance is workable. Indeed, one Blue Cross and Blue Shield Plan has begun to offer this coverage, and several other Plans have pilot programs.

However, public awareness is needed. Neither Medicare nor Medigap were designed to cover long term care but most elderly persons incorrectly believe these programs will cover them. Thus, consumer education and financial incentives appear necessary.

Therefore, we strongly support the thrust of Secretary Bowen's recent recommendations to protect the elderly from catastrophic costs of long term care by having the federal government encourage private solutions through:

- o Working with the private sector to educate the public about the risks, costs and financing options for long term care, and the coverage limitations of Medicare and Medigap.
- o Encouraging personal savings for long term care through tax-favored Individual Medical Accounts.
- o Encouraging development of private long term care insurance through:
  1) A 50 percent tax credit for persons over age 55 who purchase such insurance;
  2) Favorable tax treatment for long term care insurance reserves; and
  3) Removal of the DEFRA statutory barriers to employers' prefunding of long term care coverage for retirees.

We believe these federal activities would result in substantially increased purchase of private long term care insurance. In addition to protecting the elderly from catastrophic expenses, widespread purchase of long term care insurance would reduce federal and state expenses for Medicaid payments to nursing homes. We urge you to explore these proposed governmental incentives for private sector solutions, and would be pleased to work with you on this important issue.

Summary

In summary, we believe that the private market has functioned well in providing acute health care protection against major financial loss for the majority of Medicare beneficiaries. We recognize that there are beneficiaries, however, who cannot afford private protection. We urge that any new program focus on that segment of the beneficiary population not adequately protected by current programs. Regarding long term care, we also believe private insurance can play an important role. However, governmental activities appear necessary to educate the elderly about the need for protection, and to provide incentives for purchase of long term care insurance. Protecting the elderly from catastrophic expenses can best be done through a combination of public and private sector initiatives, and we look forward to working with you as you pursue this important topic.

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Item 3

Testimony of

GAIL SHEARER

MANAGER, POLICY ANALYSIS

CONSUMERS UNION

before the

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

hearings on

CATASTROPHIC HEALTH INSURANCE

January 26, 1987

Mr. Chairman and members of the Special Committee on Aging, Consumers Union* appreciates the opportunity to present our views on the issue of catastrophic health insurance for the elderly. In November 1986, we sponsored a conference on "Ending Poverty -- Issues for the Middle Class." One theme which emerged from the conference was that inadequate access to health care at a reasonable cost is a major barrier to escaping poverty. Many working families live on the edge of poverty or actually fall into it because they experience high, unreimbursed health care costs. As many as 37 million people in our nation face limited access to health care because they do not have health insurance. Consumers Union is committed to doing what it can to contribute to an informed debate on the critical health issues facing the 100th Congress. Today's hearings focus on catastrophic health insurance for the elderly and long-term care -- two huge gaps in the current health care system. I have attached to this testimony an analysis we prepared in response

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*Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New YOrk to provide information, education and counsel about consumer goods and services and the management of family income. Consumers Union's income is derived solely from the sale of Consumer Reports, its other publications and films. Expenses of occasional public service efforts may be met, in part, by nonrestrictive, noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports, with approximately 3.5 million paid circulation, regularly carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

to Secretary Bowen's proposals concerning the financing of catastrophic illness.

There are three key points I will make in my testimony. First, the private medicare supplement market ("medigap") has a history of poor performance, and continues this tradition today, despite piecemeal efforts at the state and federal level to regulate it. Second, Consumers Union strongly supports proposals that would expand Medicare coverage to include the costs of catastrophic illness, and believes that sponsorship by the federal government is warranted. Finally, Consumers Union strongly urges you to consider the full range of options in an effort to increase long-term care protection -- including both voluntary long-term care coverage and mandatory long term care coverage under Medicare.

Poor Performance of the Medigap Market

The experience with medigap is important to any discussion of catastrophic health insurance. Its poor record argues in favor of an expanded role for the federal government in providing catastrophic illness expense protection. In addition, reliance on the medigap model in developing proposals regarding long-term care is misplaced.

In the late 1970's, abuses in the medicare supplement insurance market were exposed by the House and Senate Select Committees on Aging, by the Federal Trade Commission, and by

several state insurance departments. In addition to marketing abuses such as "loading up" (selling multiple overlapping policies to vulnerable consumers), "twisting" (convincing a client to switch policies, thereby increasing exclusions for pre-existing conditions), "clean sheeting" (where agents ignore applicant's health problems on the application form, but leave the client vulnerable to having claims rejected later), the Federal Trade Commission found that medicare supplement policies very often had very low loss ratios (percentage of premiums collected that are paid in benefits). Moreover, it was revealed that people eligible for medicare supplement insurance policies were understandably confused about how to evaluate the available policies; and very little information about the worth of the policies existed.

In response to the documented abuses within the medigap market, the Congress passed Public Law 96-265, adding section 1882 to the Social Security Act. State insurance departments have also attempted to regulate this market, though with varying degrees of enthusiasm. Despite these efforts from federal and state governments, the problems still persist. The General Accounting Office recently reported that while the market has improved somewhat, loss ratios of most commercial policies were below the section 1882 targets, and averaged 60.2% in 1984. [Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies, General Accounting Office Report to the Subcommittee on Health, Committee on Ways and Means, October 1986, p. 4] In addition, the report found that

most states do not monitor the actual loss ratio experience [GAO Report, p. 25].

Just last year, the House Subcommittee on Health and Long-Term Care estimated that older Americans waste $3 billion annually on private health insurance because of duplicative policies and low loss ratios. [Catastrophic Health Insurance: The Medigap Crisis, Hearing before the Subcommittee on Health and Long-term Care of the Select Committee on Aging, House of Representatives, June 25, 1986, p. 146]

Consumers Union continues to find abuses in this marketplace. On October 14, 1986, the San Francisco office of Consumers Union (joined by eight other organizations) filed a petition before the California Commissioner of Insurance to halt the unfair and deceptive marketing of medigap insurance to senior citizens. The petition claimed that unscrupulous agents in California had:

(1) loaded up senior citizens with overlapping policies;

(2) caused seniors to cancel policies and replace them with new ones creating lags in coverage;

(3) misrepresented themselves as being from government agencies or independent senior organizations; and

(4) exaggerated the coverage offered by policies and failed to disclose the substantial limits and exceptions to coverage.

The California Insurance Commissioner is expected to act soon by granting a substantial portion of the petition.

State insurance commissions, the Department of Health and Human Services, and Consumer Reports (in a June 1984 article rating medigap policies) have attempted to educate consumers about medigap policies and their limits. But despite these efforts, consumers continue to be uninformed and purchase duplicative and low value policies. Consumers are confused, and for good reason. Medicare -- with its Parts A and B, coinsurance, deductibles, skilled nursing facilities, intermediate care facilities, benefit periods, lifetime reserve days, physician assignment, etc. -- is an impossible maze, defeating even the most educated consumers. It is no wonder few consumers understand that Medicare largely fails to provide long-term care coverage. Adding to this confusion, consumers must comprehend a variety of private policies marketed to the elderly (often through deceptive marketing techniques)-- medigap policies, hospital indemnity policies, dread disease coverage. It should come as no surprise that research shows that the level of knowledge the elderly have about Medicare and private insurance is extremely low. Based on the medigap market's overall performance record, there is no justification to rely on it for catastrophic or long-term care insurance.

Catastrophic Protection within Medicare

Consumers Union strongly supports the concept of restructuring Medicare to provide the elderly with protection against catastrophic illness. Secretary Bowen's proposal regarding catastrophic expenses of the elderly would greatly benefit those individuals with the most severe medical expenses. With Medicare paying less than one half of the health care costs of the elderly, there is clearly a compelling need for this protection. The cost of catastrophic illness on the elderly often imposes a serious financial burden. Data contained in Secretary Bowen's Report indicate that 10% of the elderly have out-of-pocket health care liabilities of $1000 or more a year. [Bowen Report, p. 26] Additionally, this financial burden does not fall according to ability to pay. Expected out-of-pocket expenditures represent a much larger percent of income for low-income consumers than of higher income consumers. [Changing the Structure of Medicare Benefits: Issues and Options, Congressional Budget Office, March, 1983]

We recognize that a catastrophic insurance program of the type proposed by Secretary Bowen would displace a portion of medigap policies and would force many medigap policies to restructure their benefits. We welcome this shift to the public sector, because we believe that an expanded Medicare can serve consumers far better than the private medigap market. Medicare's administrative costs are 3% [The Medicare and Medicaid Data Book, Health Care Financing Administration, 1983,

pp. 69,70], while administrative costs, marketing costs and retained proceeds for commercial medigap policies average about 40%. The private market has tried, and has been given more than enough time to rise to the challange of serving consumers. But after years of abuses and ineffective regulation, we believe it is time to try another approach.

The Bowen proposal for catastrophic illness protection continues to leave a sizable market left unfilled. We urge you to consider a medicare-sponsored policy which would fill in the remaining gaps instead of leaving the holes to medigap. An expanded Medicare would save substantial marketing and administrative costs and deliver more health benefits per dollar to consumers. Further, a public sponsored program could alleviate the labyrinthian search process for high value, comprehensive coverage.

Further Options for Long-Term Care Protection

Secretary Bowen's recommendations with regard to long-term care stress public education, tax benefits for personal savings, and tax subsidies to encourage the purchase of private insurance. We urge you to consider additional options. We fear that the private market will do no better with regard to long-term care than it has done with regard to medicare supplement insurance. Two options that we believe warrant consideration are first, a voluntary Medicare Part C to cover long-term care needs, financed in part by a premium paid by

participants and in part by cost-sharing, and second, an expanded Medicare to cover long-term care expenses for all participants.

A voluntary Medicare Part C covering costs of long-term care has several advantages over private market coverage. They include: (1) lower administrative and marketing costs; (2) greater value for money for consumers because loss ratios would be much higher than equivalent private policies; (3) reduced consumer search costs and confusion resulting from inadequate information about the worth of products in the private market; (4) increased access for all of the Medicare-eligible population to long-term care coverage because no applicants would be turned down due to poor health. (In contrast, the private market would not be able to accommodate applicants that they believe are poor risks).

The second option that should be considered is expanding Medicare to cover long-term expenses for all participants. The key drawback to this option is the significant amount of new federal dollars that would be needed to finance it. (A good portion of the expense would be a shift from Medicaid spending to Medicare spending.) Through gradual phase-in of benefits and significant cost-sharing (possibly a portion of social security checks of those using long-term care services), the impact on the federal budget could be reduced. A proposal along these lines has been developed by the Harvard Medicare Project in Medicare: Coming of Age -- A Proposal for Reform [Harvard University, 1986].

Item 4

COMMENTS OF CONSUMERS UNION*
ON CATASTROPHIC ILLNESS EXPENSES
(DEPARTMENT OF HEALTH AND HUMAN SERVICES
REPORT TO THE PRESIDENT)

January 8, 1987

INTRODUCTION AND SUMMARY

Catastrophic Illness Expenses (Department of Health and Human Services Secretary Bowen's Report to the President)(hereinafter, the Report) identifies three important segments of the health care problem facing Americans -- the need for:

1. acute care catastrophic protection for the elderly;
2. long-term care protection alternatives; and
3. catastrophic health expense protection for the general population.

The Report recommends (among other things):

1. restructuring the Medicare program to provide catastrophic protection for the elderly with an actuarially sound additional premium;
2. providing incentives through the tax system for savings earmarked for long-term care expenses and for the purchase of long-term insurance; and
3. encouraging state initiatives to extend catastrophic insurance protection to the general population.

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Consumers Union supports the recommendation to restructure Medicare Part B to provide for catastrophic protection for the elderly, financed by an additional premium. The proposal will greatly benefit the elderly with the most severe medical expenses, and is funded, appropriately we believe, by all beneficiaries.

However, Consumers Union disagrees with several policies contained in the Report. Section I of the following comments describes the inappropriateness of using the private medicare supplement insurance market as a model for long-term care insurance. In this section, we both explain why some of the Report's recommended options are not desirable and identify further options that should have been considered. Section II takes issue with the Report's reliance on the tax system as a mechanism to subsidize the savings plans and the purchase of long-term care insurance policies. Section III describes why the Report's treatment of the under age 65 population is inadequate.

I. THE PRIVATE "MEDIGAP" MARKET HAS NOT WORKED WELL AND SHOULD NOT SERVE AS A MODEL FOR THE LONG-TERM CARE INSURANCE MARKET.

The Report attempts to form a "partnership" between the private sector and the government, similar to the medicare/medigap dichotomy, to facilitate access to long term care insurance. In pursuing this partnership, the Report: (A) fails to acknowledge or give adequate weight to the private market's shortcomings; (B) recommends options that are destined

to repeat the scandals that continue to exist in the medigap market -- affecting not only the medigap market segment, but expanding the pattern of abuses into the "long-term care" market as well; and (C) totally ignores several very sound options that place less emphasis on the private market.

(A) Shortcomings of Private "Medigap" Market

In the late 1970's abuses in the medicare supplement insurance market were exposed by the House and Senate Select Committees on Aging, by the Federal Trade Commission, and by several state insurance departments. In addition to marketing abuses such as "loading up" (selling multiple overlapping policies to vulnerable consumers), "twisting" (convincing a client to switch policies, hence increasing exclusions for pre-existing conditions), "clean sheeting" (where agents ignore applicant's health problems on the application form, but leave the client vulnerable to have claims rejected later), medicare supplement policies very often had very low loss ratios (percentage of premiums collected that are paid in benefits). People eligible for medicare supplement insurance policies were understandably confused about how to evaluate the available policies; very little information about the worth of the policies existed.

In response to the abuses, the Congress passed Public Law 96-265, adding section 1882 to the Social Security Act. Catastrophic Illness Expenses refers to this legislation (p.

29), but fails to acknowledge that the market is, at best, only marginally better now than it was in 1980. The General Accounting Office recently reported that while the market had improved somewhat, loss ratios of most policies were below the section 1882 targets, and averaged 60.2% in 1984 [Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies, Report to the Subcommittee on Health, Committee on Ways and Means, October 1986]. Several companies had loss ratios in the 20 to 40 percentile range; some were even lower. Congressman Pepper held hearings on June 25, 1986 and documented the continuing abuses and waste in this market [Hearing on Catastrophic Health Insurance: The Medigap Crisis, Subcommittee on Health and Long-Term Care, Select Committee on Aging].

Continued marketing abuses and average loss ratios of 60% do not say much for the "value for money" being offered to consumers in this market. We question why "value for money" isn't a criterion used in the Report to evaluate the policy alternatives.

(B) Inappropriate Options in the Report

With regard to long-term care protection, the Bowen Report recommends (among other things):

1. Work with the private sector to educate the public about the costs of long-term care and the limitations of coverage under Medicare and medigap supplement insurance (p. 105);

2. Encourage personal savings for long-term care through a tax-favored Individual Medical Account (IMA) (p. 107);

3. Encourage the development of the private market for long-term care insurance through the establishment of a 50% refundable tax credit for long-term care insurance premiums for persons over age 65 (up to an annual maximum of $100) (p. 109).

The analysis and recommendations contained in the Report with regard to long-term care coverage for the elderly suffer from the failure to consider the adequacy of the private market to serve consumers well and from the failure to consider the complete array of options available. The Report asserts that the key reason a private market for long-term care insurance had not developed until recently is because of the absence of consumer demand (p. 104). This explanation does not reveal the whole story. The private market probably can not work well for this product because of the twin concerns that have deterred the insurance industry from offering long-term care insurance: adverse selection and moral hazard. "Adverse selection" would occur to the extent that those who choose to insure will have a better-than-average chance of needing long-term care services. A very healthy 65-year-old is far less likely to choose to invest in long-term care insurance than an unhealthy 65-year-old of the same financial status. Insurance companies, understandably from a profit viewpoint, aim to select the most healthy for coverage. "Moral hazard" occurs to the extent that people who have long-term care coverage are less likely to

explore all alternatives to long-term care (e.g., assistance of family members) and hence are more likely to use the coverage. In other words, a person with custodial care needs who has comprehensive nursing home insurance faces a different array of choices than a person without such coverage. The existence of the insurance coverage lessens the incentive to explore home health care and other custodial care alternatives. Despite these risks, a private market is emerging. But we don't yet have information on what pricing policies, policy coverage provisions, and underwriting practices insurance companies will use to deal with these problems.

The experience with medigap policies -- averaging, as noted above, loss ratios of only 60% -- is great cause for concern. Can we honestly expect that long-term care policies will have loss ratios more favorable to consumers than 60%? Is it a wise expenditure of limited dollars of the elderly, and subsidization from taxpayers, for policies returning 20%, 30%, or even 60% of premiums in the form of insurance benefits? Further the Report's reliance on education of consumers about the risks of the high costs of long term care and on increasing incentives to purchase private long-term care insurance is inadequate. Further options should be considered. (See section (C)(2) of these comments.)

(C) Options Excluded from the Report

(1) Acute Care Coverage: The Report recommends that Medicare be restructured to provide catastrophic protection

(with a $2000 annual limit) for an extra premium of about $5 per month. This option would displace a portion of medigap policies and would force many medigap policies to restructure their benefits. (When Medicare cost-sharing amounts increase, medigap policies often increase their coverage to fill in the increased Medicare gaps; similarly, when Medicare benefits increase, medigap policies need to adjust their coverage so as not to duplicate the coverage Medicare provides.) We recognize that the Report focussed on catastrophic care. However, if the Report weighed the medigap market problems more heavily, we believe it would have at least considered a more ambitious expansion of Part B. What about a federal-government-sponsored medigap policy? (This would merely expand the Report's recommendation to cover deductibles, coinsurance, and possibly drug costs that do not reach the catastrophic level of $2000 per year). The Harvard Medicare Project recently made a proposal for a Medicare-sponsored insurance policy. [See Medicare: Coming of Age -- A Proposal for Reform, March 1986, p. 19]. Under this program, marketing and administrative cost savings would be significant. To preserve the partnership with the private sector, the government could have private companies compete to administer the program.

In order to preserve freedom of choice for consumers, two levels of Part B voluntary coverage could be established; level 1 would include current plus catastrophic coverage; level 2 would include in addition the expanded medigap coverage. This

adds to the complexity of Medicare, but simplifies the overall task consumers face since they no longer would need to shop for one (or multiple) private policy(ies).

(2) Long-Term Care Coverage: As summarized in section I (B) above, the Bowen Report's recommendations with regard to long-term care stress public education and subsidization of private insurance. The Report's analysis should have considered two additional options: (a) a voluntary Medicare Part C to cover long-term care needs, financed in part by a premium paid by participants and in part by cost-sharing and (b) expanding Medicare to cover long-term care coverage for all participants.

(a) Voluntary Medicare Part C. Karen Davis and Diane Rowland outline a proposal for a voluntary long-term care coverage of the elderly in their book Medicare Policy: New Directions for Health and Long-term Care [The Johns Hopkins University Press, Baltimore, 1986, p. 110 -119.] Congressman Pepper introduced H.R. 4287 in the 99th Congress, "to amend title XVIII of the Social Security Act to provide for an optional part C program to furnish comprehensive, catastrophic, long-term, and preventive benefits through prepaid plans." Key advantages of a government-sponsored program include: (1) low administrative and marketing costs; (2) greater value for money for consumers because loss ratios will be much higher than equivalent private policies; (3) reduced consumer search costs and confusion that results from inadequate information about the

worth of products in the private market; (4) increased access for all of the Medicare-eligible population to long-term care coverage because no applicants would be turned down. (In contrast, the private market will not be able to accommodate all applicants). Drawbacks would include a reduction in the array of choices available to consumers.

(b) Medicare coverage of long-term care. For the sake of completeness, we believe that the Report should have included analysis of the option of expanding Medicare to cover long-term care coverage for all of the Medicare-eligible. The Harvard Medicare Project discusses this option [See Medicare: Coming of Age--A Proposal for Reform, pp. 20 - 31.] Even if this option included cost-sharing, it is likely to require a significant amount of additional money from the federal budget.

II. THE REPORT'S RECOMMENDATIONS PLACE INAPPROPRIATE RELIANCE ON THE TAX SYSTEM.

Despite the tax policy established in the recent tax reform act, some of the Report's recommended options involving long-term care use the income tax system to subsidize the purchase of insurance. (See section II (B) above for a brief description of proposals for tax-favored Individual Medical Accounts and tax credits for private long-term care insurance.) Consumers Union supports the use of the tax system to promote worthy social goals when (1) the social good to be obtained exceeds the cost, and (2) the benefits and the costs of the program are equitably distributed. We do not believe that the recommendations in the Bowen Report regarding tax-favored IMAs and tax credits for long-term care insurance meet these tests.

Consider first the proposal for Individual Medical Accounts (IMAs). Under the proposal "[i]ndividuals would be permitted to deposit a certain amount of money (e.g. $1000 maximum) each year into a savings account restricted to use on long term care expenses. Interest accumulations would be tax free and withdrawals would not be taxed or penalized as long as their use was for nursing home care" (p. 107). (In discussing this option, the Report suggests that IMA deposits might be excused from taxation (as are Individual Retirement Accounts) or qualify the depositor for a limited tax credit (p. 78). "Fifty percent of the interest on the account would be used to fund a risk pool that would cover expenses incurred for nursing home care after the balance in the account had been exhausted" (p. 78-79).

This proposal is very complicated and the Report fails to analyze its likely impact. Our key concerns are: (1) The people who are likely to fund an IMA are likely to be those with the highest incomes. Low income families simply would not be able to afford the contribution. Middle income families would be likely to fund IRAs first (if eligible) and might then consider whether to participate. The difficulty of predicting future expected benefits of contributing to an IMA would discourage participation. Overall, we would not predict a very high participation level; (2) the costs are borne by <u>all</u> taxpayers; as federal tax revenues are expended on this program, all taxpayers bear the cost. Hence, we believe that the IMA proposal's costs may exceed its social good, and that its benefits and costs are inequitably distributed.

Similarly, the proposal for a 50% tax credit for long-term care insurance premiums for persons over age 55 (p. 109) is not likely to yield net social benefits. Our key concerns are: (1) the private long-term care market will not perform any better than the medicare supplement insurance has and the tax credit will end up subsidizing insurance industry profits rather than patient care (see section I above); (2) the policies are going to be available only to a portion of the Medicare-eligible population. They will not be available, in particular, to the least healthy elderly, who are most likely to need long-term care services; (3) the "tax expenditure" (i.e., lost federal revenue) is likely to be considerable, and will be borne by all taxpayers. In sum, the costs of this proposal may exceed the social good, with inequitable distribution of the costs and benefits.

The Report also recommends changing tax treatment for long-term care insurance reserves, to make it more favorable to the insurance industry (p. 109). This is based on a "trickle down" theory that some of the savings might be passed through to consumers. It is not clear that taxpayers should be forced to pay the cost of what is at best a questionable savings to consumers of private long-term care coverage.

The tax system creates subsidies that are hidden from policy makers. It is interesting to note that the federal government spends approximately the same amount on its contribution to the Medicaid program as it does for the exclusion from taxes of employer contributions for medical

insurance premiums and medical care. Yet Medicaid for the poor is considered a handout, while employer-provided health insurance is a perfectly acceptable fringe benefit of employment.

III. THE REPORT'S CONSIDERATION OF THE UNDER 65-YEAR-OLD POPULATION IS INADEQUATE.

Catastrophic Illness Expenses does not do justice to the growing and severe problem of the lack of insurance for the under 65-year-old population. This problem is worthy of a study of its own. The Report recommends an array of options to address the catastrophic illness expenses of the general population -- but the significance is illusory. The Report merely recommends that states adopt certain measures. No recommendation for federal assistance to the states or federal incentives is suggested. It is unlikely that the recommendations will lead to any real improvement in the under 65-year-old population's access to catastrophic health insurance. A few specific comments:

(A) Catastrophic vs. Non-catastrophic Coverage. The distinction between catastrophic and non-catastrophic coverage needs is not always precise. For low-income families, a mild but chronic health condition can pose catastrophic expenses. Even for a moderate income family, chronic conditions that require treatment year after year can impose a great financial burden yet fail to qualify as "catastrophic" under policy-makers' criteria.

(B) State risk pools. If the goal is to increase the adoption of state risk pools, it is not sufficient to merely "encourage the formation of state risk pools to subsidize insurance for those whose medical condition makes it impossible or prohibitively expensive to get insurance." [p. 114]. Legislation is needed to provide states with strong incentives to establish such risk pools.

(C) Medicaid Expansion Option. One positive option discussed in the Report is not recommended: "Permit all individuals below some income level to purchase Medicaid coverage on a sliding premium scale depending on income." [p. 87]. The Report estimates that if the plan included all people under 125% of the poverty line, with premiums limited to 5% of income could cost as much as $15 billion if all eligible people enrolled. The Report fails to estimate the cost savings that would be achieved: many people presently on AFDC and medicaid are deterred from taking a job because they will become ineligible for medicaid and will be unable to obtain affordable health insurance. Note also that even this inflated cost estimate is less than the present federal subsidy for the exclusion from taxation of the employer-paid health insurance premiums (which benefit primarily middle and upper-income people).

Item 5

Consumers Union
Publisher of Consumer Reports

February 17, 1987

Senator John Melcher, Chairman
Special Committee on Aging
United States Senate
Washington, D.C. 20510-6400

Dear Senator Melcher:

I appreciate your invitation to testify at the Special Committee on Aging's January 26, 1987 hearing on catastrophic health care costs. While my testimony of that date sets out Consumers Union's overall position on catastrophic health insurance, I would like to submit some additional comments in response to the statement of the Health Insurance Association of America (which was presented by Mr. Robert Shapland).

Consumers Union strongly disagrees with the HIAA portrayal of medigap insurance as "a public/private sector success story" and with the view that "the current combination of private and public coverage is serving the public well." While it is true that 70% of the elderly have purchased private health insurance to supplement Medicare, this in itself is not indicative of a healthy marketplace. Problems that remain in this market include:

1. Duplicative policies. Many Medicare-eligible continue to be sold overlapping, duplicative policies. Our San Francisco office identified a 79-year-old woman with five overlapping medicare supplement policies, three nursing home policies and one hospital indemnity policy, amounting to $6500 per year in premiums. Other couples were found to have $10,000 and $13,000 worth of overlapping medigap policies.

2. Inadequate information. The level of understanding of just what Medicare and Medicare supplement policies cover continues to be very low. For example, 70 percent of the population over age 65 believes that Medicare would cover any long nursing home stay, and half of those with medigap policies believe that they are covered for long-term care expenditures.

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3. Deceptive marketing practices. Throughout California (and probably in other states as well), senior citizens have been sent mailings that appear to be official government notices of cuts in Medicare benefits and the need to buy medigap insurance. In fact, the mailings are from an insurance company and firms which develop and sell sales leads to insurance agents.

4. High cost/low value. Finally, Medicare supplement insurance policies tend to be relatively high-cost, low-value policies. Premiums range from $150 to $1,500 per year. Loss ratios, the percentage of premiums collected that are paid in benefits, average 60% for commercial medicare supplement policies, according to a recent GAO report. This means that on average the costs of marketing, administration, and profits consume 40% of premiums collected from consumers. Mutual of Omaha, the company that Mr. Shapland represents, had a loss ratio of 51.0%. This is not a record to be particularly proud of, especially in light of the target minimum loss ratio of 60% that Mr. Shapland mentions. By way of comparison, Medicare's administrative costs are 3% of revenues. Displacing all or part of the private market by an expanded Medicare promises to increase consumers' value-for-money.

Consumers Union strongly endorses expanding Medicare to cover the costs of catastrophic illness, and believes that sponsorship by the federal government is warranted. We urge you to remember the poor performance of the medigap market in considering options for long-term care.

Thank you for the opportunity to present these additional views.

Sincerely,

Gail Shearer

Gail Shearer
Manager, Policy Analysis

Item 6

THE WHITE HOUSE

Office of the Press Secretary

FOR RELEASE AT 9:00 P.M. (EST)
TUESDAY, JANUARY 27, 1987

THE PRESIDENT'S INITIATIVE ON
CATASTROPHIC ILLNESS COVERAGE

FACT SHEET

The President recognizes that catastrophic illness can debilitate individuals and families financially, emotionally and physically. In proposing new initiatives to protect against the financial costs of catastrophic illness, the President is looking for ways to protect the millions whose present coverage is either non-existent or inadequate.

Coverage Under Present System

The American health care financing system is a broad network of private insurance mechanisms and public programs which, taken together, protect the majority of persons from the financial costs of catastrophic illness. Many people, however, still fear that potential devastating illnesses can destroy their financial security.

In addressing the catastrophic illness problem in the United States, there are three groups of people to consider: the general population under age 65; the elderly facing long-term care expenses; and the elderly facing acute-care expenses. The risks that these groups face are different, and programs to deal with their problems must vary accordingly.

1. General Population Under Age 65

The majority of the general population is covered by employment-related group health insurance with costs borne by employers as one component of fringe benefit packages. A large number of persons who do not work are covered for health expenses by Medicaid, a program designed for the elderly poor, the blind, disabled persons, and poor families with dependent children.

There are, however, an estimated 30 million people under the age of 65 who have no health insurance at all, and 10 million who have inadequate coverage for catastrophically high expenses. Many are self-employed or are employees of firms that do not offer group health insurance to their employees. Federal, State, and local governments annually spend several billions of dollars to care for the uninsured.

2. Elderly Americans Under Long-Term Care

The urgency of long-term care is an increasingly important policy issue. By the year 2030, an estimated 8.6 million Americans will be over the age of 85, compared to 2.7 million in 1985.

About 1.4 million elderly now receive care in nursing homes, at an average expense of over $22,000 a year. These costs are not covered by Medicare or private insurance, although many elderly are under the impression that they are. Of the $32 billion in 1985 nursing home costs, less than 2 percent was paid by private insurance. Of the remainder, half was paid out of savings of patients and their families and the other half was covered by Medicaid.

3. Elderly Under Acute Care

Virtually all elder Americans are entitled to acute care coverage under Medicare. Nearly two-thirds also supplement their coverage with so-called "Medigap" policies purchased in the private insurance market.

Medicare is designed as an acute care coverage program. Much of the costs of physician services and of hospital stays under 60 days are covered. Longer hospital stays are not fully covered and prescription drugs are not covered at all. Some Medigap policies cover these additional expenses, but many do not.

The major source of fear for the elderly is that they could be faced with expenses that are not covered either by Medicare or Medigap. In addition, confusion often exists over what acute care coverage the elderly have and do not have. Some elderly buy too much insurance, while others believe they have more coverage than they actually have.

Administration Proposal

The President's Initiative on acute care Catastrophic Illness Insurance for the elderly is based on the following guidelines:

- We must provide meaningful protection against out-of-pocket expenses that substantially threaten family savings;
- The importance of Medicare, Medicaid and Medigap should be maintained and we should not encourage excessive use of services;
- Any catastrophic illness coverage should be voluntary, not a new government entitlement; and
- The proposal must be fully budget-neutral, without the explosive potential of program expansions.

The President, in his 1987 State of the Union Address, spoke of the "specter" facing older Americans -- that of often having to make an "unacceptable choice between bankruptcy and death." The President will submit legislation shortly to free the elderly from the fear of not being able to meet the costs of catastrophic illness.

Item 7

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Pressing Concerns About Medicare:
The Patient Advocate's Perspective

Testimony Presented to
the United States Senate Special Committee on Aging

By Judith Stein Hulin
and
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I. INTRODUCTION

We are the Co-Directors of the Center for Medicare Advocacy, a non-profit organization located in Willimantic, Connecticut which provides legal representation to low-income elderly and disabled people who have been unfairly denied Medicare benefits. We have been assisting Medicare beneficiaries since 1977; from 1977 until April 1986, we were the Co-Directors of Legal Assistance to Medicare Patients, a project of Connecticut Legal Services, Inc. During the past nine years, our colleagues and we have taken more than 1,000 Medicare appeals to administrative hearing, winning more than 70 percent. We have also litigated 22 class action lawsuits in an effort to resist attempts by the Health Care Financing Administration to restrict and deny illegally the Medicare coverage to which Medicare beneficiaries are entitled, and the health care services which Medicare beneficiaries desperately need.

In our practice, we speak with many beneficiaries and their families every day. We have also developed a large database containing significant information regarding hundreds of individual patients. All in all, we believe we have a unique "window" on the real life situation of beneficiaries struggling to arrange financing for the health care services they require.

Our experience over the years convinces us that our present health care financing system is failing to finance the medical care our citizens have a right to expect. First, certain crucial "gaps" in the Medicare program as written by Congress mean that beneficiaries are for the most part unprotected against the catastrophic cost of nursing home and home health care. Second, the Health Care Financing Administration has taken steps to restrict, radically and illegally, the degree of Medicare coverage presently provided by law. The end result is a system which leaves patients vulnerable to the enormous and destructive cost of long term care. Forced to depend on their own limited resources, beneficiaries, in a misguided attempt to economize, will often deny themselves essential medical care. They become poor and are forced onto welfare. They are unable to sustain themselves in the community, and must enter institutions.

The final irony is the fact that a system which fails to protect against the cost of catastrophic illness is profoundly uneconomic. The present financing structure fails to assist patients while they are financially solvent and still have a chance to regain their health and live independently. Instead, we encourage patients to become disabled, institutionalized, and indigent, at which time the Medicaid program absorbs the enormous cost of long term nursing home care. These huge Medicaid expenditures would not be necessary had adequate financial help been available when it was first needed.

II. NURSING HOME CARE

The Medicare program pays for less than three percent of the nursing home care our citizens need. Although Medicare nursing home coverage is often unfairly denied, even if every patient received the full coverage to which he or she is entitled, we estimate that Medicare would cover no more than approximately 20 percent of all nursing home charges. The remaining 80 percent would still have to be paid by the patient privately or, once the patient is poor, by Medicaid.

Medicare nursing home coverage is restrained by several crucial statutory conditions. First, coverage is available only if the nursing home stay is preceded by a hospital stay of at least three days. Thus the many patients who require nursing home care without having first been acutely ill will be denied all coverage. Second, Medicare pays only for a "skilled nursing facility" level of care. Unless a patient requires daily skilled nursing or rehabilitation services, Medicare coverage will once again be unavailable. Many people residing in nursing homes do not require daily skilled care. Their institutionalization is required because of their need for "custodial" care such as help with meals and feeding, ambulation, dressing and bathing, and the accurate dispensing of prescription medications. These services, although essential to a patient's well-being, are not considered skilled, and no Medicare coverage is permitted. Third, even when patients do need skilled care, as certified by their attending physicians, HCFA's restrictive coverage policies lead to routine Medicare denials based on the unsubstantiated pretense that the care is "custodial."

Nor does private insurance assist with the cost of nursing home care once Medicare coverage is denied. The "supplemental" insurance now available on the market is supplemental to Medicare; such policies will pay the co-insurance for those days for which Medicare coverage is granted. If Medicare coverage is denied, the supplemental insurance coverage will also be denied. Although there has been much talk about long term care insurance which would cover nursing home expenses even where Medicare coverage is not awarded, these policies are intended for people still working. They will generally not be available to those who are already aged or disabled.

The practical effect of the huge gap in Medicare nursing home coverage is devastating. Every day we speak with beneficiaries and family members who are undergoing the "spend-down" process. At a monthly rate of $2,000 or more, nursing home care will soon exhaust the resources of all but the most affluent. In fact, a recent study in Massachusetts showed that a typical nursing home resident in that state was reduced to indigency after only 13 weeks.

III. HOME HEALTH CARE

As is true in the nursing home context, Medicare coverage for home health care is often unfairly denied. Even if Medicare home health coverage was granted in accordance with the statute, however, a huge and destructive gap in the financing for home health care would still exist. The Medicare Act stipulates that home health coverage will be available only where the beneficiary is confined to the home, and requires part time skilled care. If a patient is able to leave the home without assistance, or if no need for skilled care exists, no Medicare coverage is possible. The effect of this limitation is to burden many beneficiaries with the cost of the supportive services they require if they are to continue living in the community. Many patients can live at home if they receive just a few hours a week of assistance by home health aides. Home health aides can help with medications, bathing, and meal preparation, for example. The private rate for

aide services, however, usually exceeds $10 per hour. Even if an individual needed aide services only four hours per day, seven days a week, he would have to pay $1,200 per month or $14,400 per year. This is a crushing burden for many people on limited incomes. Because of their inability to afford these charges, many patients either continue at home with dangerously inadequate care, or are forced to enter nursing homes. Thus instead of helping beneficiaries with the relatively modest cost of home health care, our financing system will often force patients into institutions where the huge monthly rates will soon be borne by the Medicaid program.

IV. INPATIENT HOSPITAL REHABILITATION

For many years, Medicare patients in need of the kind of multidisciplinary, coordinated rehabilitation available only to hospital inpatients, have also been faced with restrictive Medicare coverage policies. Too often these restrictive policies result in patients being unable to gain access to this important, restorative care or to patients being prematurely discharged. Typically, the patient in need of hospital rehabilitation has suffered a stroke, traumatic brain injury, paralysis, and/or amputation. With an intense program of multidisciplinary therapy (often including physical therapy, occupational therapy, speech therapy, and rehabilitative nursing) provided by a team of professionals and coordinated by a physician trained in rehabilitation, these patients can often regain sufficient independent function to return home.

Unfortunately, the Health Care Financing Administration often denies coverage for this care on the basis of arbitrary rules and erroneous conclusions. Patients are denied coverage because they do not need three hours per day of physical and occupational therapy (the "3-Hour Rule"), although they may need speech therapy and other rehabilitative care. Patients are denied because their amputations are "only" below the knee, or because they "only" have upper extremity paralysis. Many are denied coverage on the unsubstantiated premise that they could receive the intense, coordinated, multidisciplinary rehabilitation they need at a skilled nursing facility or as an outpatient. The Center is responding to this dilemma for elderly and disabled patients in a variety of ways:

1. A new partnership has been formed between Gaylord Hospital in Wallingford, Connecticut, a free standing rehabilitation hospital, and the Center for Medicare Advocacy. Center staff are working in conjunction with Gaylord Hospital to appeal unfair Medicare denials for Gaylord's patients.

2. Individual appeals are being taken for patients referred to the Center. Appeals are presently in progress for patients denied Medicare who do not meet the "3-Hour Rule" and who are below-the-knee amputees, but whose physicians have certified that inpatient hospital rehabilitation is medically necessary.

3. Center attorneys are continuing to litigate the class action lawsuit, Hooper v. Bowen, H-80-99 (RJB) D. Conn 5/1/85. Hooper has been certified as a class action comprised of all Medicare patients in New England who have been denied Medicare coverage for inpatient hospital rehabilitation despite physician certification that such care is reasonable and necessary. The United States District Court for the District of Connecticut has issued a series of decisions, the latest on May 1, 1985, finding that the criteria used by HCFA to deny Medicare coverage are void and of no effect for failure to publish in the Federal Register because they include more restrictive and burdensome criteria than exist in

the Medicare Act. A copy of the Hooper decision is appended here. The Secretary of the Department of Health and Human Services responded to the court ruling by publishing the same criteria as a "Ruling" in July 1985. On behalf of the plaintiffs, the Center then urged the court to find that the criteria as published violate the Administrative Procedure Act because they were published without an opportunity for public comment, and also to find that they violate the Medicare Act because they establish criteria which are more restrictive than the Act.

On May 13, 1986, the court issued a pre-trial order requiring the parties to attempt to reach a settlement. Despite the Center's best efforts, and the support of over 30 physicians and other rehabilitation hospital specialists, the Health Care Financing Administration refused to accept any changes to Medicare's coverage criteria. The case has now been scheduled for another court appearance.

4. The Center is producing written materials to help Medicare patients, their helpers, and providers, assess Medicare denials for inpatient hospital rehabilitation and to appeal cases through the first stage of appeal, the "Reconsideration." Center attorneys are also speaking at gatherings of patients and providers concerned with this issue of vital importance to the elderly and disabled.

V. INAPPROPRIATE MEDICARE DENIALS AND THE INEFFICACY OF APPEAL

Even if it is not possible to extend current statutory entitlements to meet the full cost of catastrophic illness, certainly the coverage presently mandated by law should actually be available in the field. Unfortunately, the Health Care Financing Administration has taken steps to ensure that Medicare skilled nursing facility, home health, and hospital rehabilitation coverage is radically restricted.

The United States District Court for Connecticut has recently recognized Medicare coverage abuses in the skilled nursing facility area. District Court Judge Jose A. Cabranes issued a Memorandum of Decision on April 23, 1986 in the case of Fox v. Bowen (Civil Action No. H-78-541 (JAC)), a class action lawsuit originally filed in 1978. A copy of the Fox decision is appended here. Judge Cabranes found that although Medicare law requires that coverage be granted to patients receiving daily physical therapy treatments, the Health Care Financing Administration actually awarded coverage "to only a small number of patients who demonstrate a rapid recovery of body function. Even these patients generally receive no more than two weeks of coverage."

Judge Cabranes found that HCFA uses arbitrary presumptions or "rules of thumb" to deny coverage, rather than conducting "an individualized assessment of [a patient's] need for daily physical therapy based on the facts and circumstances of his particular case."

The judge also noted that patients unfairly denied Medicare coverage are forced to pay for physical therapy with their own funds. As Judge Cabranes stated: "In such circumstances, many patients forego medically necessary physical therapy because they or their families believe they cannot afford to pay for such therapy themselves." Loss of therapy jeopardizes the patient's recovery. If "more elderly persons receive physical therapy after sustaining a stroke or fracture, fewer of these persons would have to spend the remainder of their lives in nursing homes." Moreover, if patients were able to live independently, it would "actually reduce the 'fiscal burdens' on the federal and

state treasuries."

Judge Cabranes entered an order enjoining the use of arbitrary and inflexible practices in determining a patient's entitlement to physical therapy coverage, and requiring the Secretary of the Department of Health and Human Services to give an individualized evaluation of each patient's medical condition and therapeutic needs. The judge also held that all members of the plaintiff class are entitled to a reconsideration of their claims. The Health Care Financing Administration, however, is resisting implementation of this decision; to date no order is in place and nursing home patients are still being regularly and arbitrarily denied Medicare coverage despite their need for daily skilled care.

Similar difficulties afflict beneficiaries attempting to secure Medicare home health coverage. Recently, the Center for Medicare Advocacy filed a lawsuit in federal district court in Bridgeport on behalf of a disabled Stratford resident. The plaintiff in the lawsuit, Mr. Robert Huda, is a 56 year old victim of multiple sclerosis and stroke whose ability to continue living at home had been threatened by Medicare's arbitrary denial of coverage for home health aide services.

Mr. Huda has been able to live at home because he has been receiving 25 hours of home health aide services each week. Because Mr. Huda is totally dependent upon others, aides must feed and bathe him, protect him from choking, move him from bed to chair, and, in general, assist him in all his activities of daily living. Since Mr. Huda had no other help during the day, home health aide assistance was mandatory if he was to avoid nursing home placement.

The Medicare program, however, denied Mr. Huda coverage for his home health aide services on the ground that his condition was "chronic," a criterion of coverage which appears nowhere in the statute or regulations. Mr. Huda initiated an administrative appeal to challenge this denial. Because of delays in the administrative process, however, it would have been many months before an appeal decision was issued, and the home health agency required concurrent payment if it was to supply aide services. Mr. Huda could not afford to purchase this care. Although the Medicare denial of coverage was completely without justification, and the merits of Mr. Huda's appeal were of overwhelming strength, he was likely to suffer irreparable harm before his appeal was heard. Mr. Huda was, therefore, compelled to file a federal court action asking the court to require the Medicare program to make payment for the home health aide services Mr. Huda required during the pendency of his administrative appeal.

On October 2, 1986, Federal District Judge Warren W. Edginton issued a temporary restraining order requiring Medicare to grant coverage for the 25 hours per week of home health aide services Mr. Huda required. On October 6, 1986, Mr. Huda received notice that the previous denials of Medicare coverage he had received would be rescinded, and that coverage was likely to be available for the indefinite future.

The Huda case epitomizes the dilemma in which many home health beneficiaries find themselves. A Medicare denial is usually a "fait accompli." Few beneficiaries have the strength to undertake an appellate process which will involve delays exceeding twelve months between initial denial and administrative hearing decision. Even if they are able to appeal, most beneficiaries are unable to arrange non-Medicare financing of the care they need while the appeal is pending. Without adequate care, patients are typically forced out of the community into a nursing home. This would have been Mr. Huda's fate had he not been able to locate legal assistance, and prosecute aggressive legal action. Few beneficiaries have access to effective legal

representation, however. It is our belief at the Center for Medicare Advocacy that many hundreds of nursing home residents now residing in nursing homes in Connecticut could be maintained safely at home in the community if a fair degree of Medicare home health coverage was made available.

VI. CONCLUSION

We applaud the Senate Special Committee on Aging for undertaking this desperately needed examination of the impact of catastrophic health care expenses. We are convinced that rational and compassionate planning and legislation can devise a financing structure which will avoid the senseless human and economic costs of needless institutionalization and indigency. We are also convinced that Congress must take a more active role in ensuring that the Health Care Financing Administration executes the Medicare law in a way which accurately reflects Congress' intention to meet the health care financing needs of our elderly and disabled.

There is also no need, as the provider suggests, to set up a different patient billing department for the emergency room physicians' billing services. The revenue offset is designed to offset those costs incurred by the provider which are not reimbursable costs related to patient care pursuant to 42 CFR 405.451. The billing revenues retained by the provider relate strictly to the cost incurred in providing the billing service. This is evidenced by the agreement between the physicians and the hospital which provides that payments to the hospital for the billing services are to be in an amount which has been determined by the parties to correspond to the hospital's actual costs.

Accordingly, the decision of the Provider Reimbursement Review Board that the Intermediary properly reduced the provider's administrative costs by the billing revenue received from the emergency room physicians is affirmed.

This constitutes the final administrative decision of the Secretary of Health and Human Services.

[¶ 34,619] Hooper v. Harris.

U.S. District Court, District of Connecticut. No. H-80-99 (MJB), May 1, 1985.

Medicare: Inpatient Hospital Rehabilitation Coverage

Medicare Part A coverage—Inpatient hospital rehabilitation coverage.—The earlier decision of this court—that a 1976 HCFA Bulletin restricting coverage of inpatient hospital rehabilitation services was a substantive rule and, therefore, should have been published in the *Federal Register*—is reaffirmed. The Bulletin applied a restriction to Region I (New England) intermediaries and hospitals that was not applicable nationwide through the *Medicare Intermediary Manual*—this restriction refused coverage of rehabilitation services provided on an inpatient hospital basis unless the patient's condition otherwise necessitated that the services be rendered on an inpatient hospital basis. This restriction was used to deny coverage for rehabilitation services provided in a hospital when such services could have been provided at a lower cost facility insofar as the patient's condition was concerned, but where the services were unavailable at such lower cost facilities. HCFA is ordered to send notices to all affected intermediaries, hospitals, and PROs that the policies contained in the Bulletin are not to be followed.

See ¶ 1231.73, 13,510.035.

Notices, determinations, and appeals—Court jurisdiction—Exhaustion of administrative remedies.—Exhaustion of administrative remedies is not required for jurisdiction in a case involving a procedural challenge to HCFA's method of promulgating restrictions on the provision of rehabilitation services on an inpatient hospital basis because: (1) plaintiffs were trying to correct a procedural deficiency collateral to a claim for benefits, (2) pursuing administrative remedies would be futile, and (3) irreparable injury was demonstrated in that many of the plaintiffs were too old, sick, and poor to await the conclusion of a lengthy administrative reviewing process.

See ¶ 13,540.035.

The earlier decision in this case was reported at 1984-1 Transfer Binder ¶ 33,528.

[Text of Decision]

BLUMENFELD, District Judge: On November 17, 1983, this court approved Magistrate Eagan's Recommended Ruling, filed September 21, 1983, on Cross Motions for Summary Judgment in this case, granting the plaintiffs' motion for summary judgment and denying the defendant's motion for summary judgment.[1] On January 5, 1984, the court issued a judgment declaring Health Care Financing Administration (HCFA) Region I Bulletin No. 175 invalid.

The motions now before the court, all of which seek to alter the judgment in some respect, were also referred to Magistrate Eagan, who filed a Recommended Ruling (hereinafter referred to as "the Second Recommended Ruling") on November 21, 1984.[2] The defendant has filed objections to the Second recommended Ruling, and the plaintiffs have filed a memorandum in support of the Second Recommended Ruling.

I. *Factual Background*

The pertinent facts are set forth in the Magistrate's Second Recommended Ruling at 2-4, and are as follows:

> The underlying case concerns the HCFA Region I Bulletin No. 175. The Bulletin establishes criteria for Medicare coverage of inpatient hospital rehabilitative services in addition to criteria set forth in the Medicare

[1] This Recommended Ruling is attached as Appendix A [see 1984-1 Transfer Binder ¶ 33,528].

[2] The Second Recommended Ruling is attached as Appendix B [omitted by CCH].

Act and in the HCFA *Part A Intermediary Manual*, Section 3101.11. The criteria for coverage under § 3101.11A provides that a patient is deemed to require a hospital level of care if he requires a relatively intense rehabilitative program, consisting of a multidisciplinary coordinated team approach to upgrade the ability to function as independently as possible, which is reasonable and necessary. Bulletin No. 175 added the requirement that the patient's condition must "*also otherwise necessitate* that the services be rendered on an *inpatient* hospital basis in order for coverage to be possible under the Medicare program." (Emphasis added).

The original complaint challenging the Bulletin was filed on February 13, 1980, as a class action in which the plaintiffs sought declaratory and injunctive relief. The defendant Secretary of Health and Human Services filed a Motion to Dismiss, in which she raised the issues of jurisdiction and failure to exhaust administrative remedies. The motion was denied on November 7, 1980. The plaintiffs' Motion for Class Certification was granted on March 25, 1982, and the class was defined to include—

"all persons residing in Health Care Financing Administration Region I, (New England), who, pursuant to the defendant's unlawful policy and practice, have been or will be denied Medicare Part A benefits for inpatient hospital rehabilitative services."

As noted previously, both parties filed motions for summary judgment and the plaintiffs' motion was granted. In granting the plaintiffs' motion, we found Bulletin No. 175 to be invalid on the grounds that the defendant Secretary failed to publish agency policy and a proposed rule imposing additional, more restrictive coverage criteria, in violation of the Freedom of Information Act, 5 U.S.C. § 552, and the Administrative Procedures Act, 5 U.S.C. § 553, respectively. Judgment was entered accordingly on January 5, 1984.

On January 31, 1984, the plaintiffs filed a Motion for a More Specific Order "[i]n order to assure that the court's judgment is implemented and that their rights are properly safeguarded." Memorandum in Support of Plaintiffs' Motion for a More Specific Order, p. 2. On February 29, 1984, the Secretary filed her opposition to the plaintiffs' motion and also filed a Request for Reconsideration in which, in essence, she reargued jurisdictional issues and the publication issue which had been found for the plaintiffs. In June, the defendant Secretary filed an additional motion, this time a Motion to Alter or Amend Class Certification. The impetus for this motion was the supreme court's decision in *Heckler v. Ringer*, [— U.S. —,] 104 S.Ct. 2013 (1984), which addresses jurisdictional issues pertinent to this case. All matters raised by the above motions have been fully briefed by the parties. *Id.* (footnotes omitted).

II. *Motion for Reconsideration*

This court remains convinced that HCFA Region I Bulletin No. 175 is invalid for lack of publication in the *Federal Register* as required by Section 552(a)(1)(D) of the Freedom of Information Act, 5 U.S.C. § 552(a)(1)(D) (1982). The Freedom of Information Act (FOIA) provides, in part, that

(a) Each agency shall make available to the public information as follows:

(1) Each agency shall separately state and currently publish in the Federal Register for the guidance of the public—

. . . .

(D) substantive rules of general applicability adopted as authorized by law, and statements of general policy or interpretations of general applicability formulated and adopted by the agency; . . . .

A "statement[] of general policy" or an "interpretation[] of general applicability" does not come within the purview of Section 552(a)(1)(D) if only a clarification or explanation of existing laws or regulations is expressed, or if no direct or significant impact upon the substantive rights of any segment of the public results. *Anderson v. Butz*, 550 F.2d 459, 463 (9th Cir. 1977) (citing *Lewis v. Weinberger*, 415 F. Supp. 652, 659 (D.N.M. 1976)). See *United States v. Hayes*, 325 F.2d 307, 309 (4th Cir. 1963). As set forth in the Magistrate's Recommended Ruling on Cross Motions for Summary Judgment, appendixed hereto, Bulletin No. 175 does not merely clarify or explain existing law but establishes additional and more burdensome criteria for Medicare coverage of inpatient hospital rehabilitative services, which have had a direct and significant impact on those seeking health care benefits in Region I (New England). The defendant in her motion for reconsideration merely repeats arguments that have previously been considered and rejected by this court and the Magistrate.[3] Accordingly, the defendant's Motion for Reconsideration is denied.

[3] The Secretary argues that the Magistrate erred in finding that Bulletin No. 175 establishes criteria for Medicare coverage of inpatient hospital rehabilitative care in addition to the criteria set forth in the Medicare Act. The Secretary points to sections of the Act which bar coverage if the patient's needs could be met in a skilled nursing facility, or if the inpatient care is not medically necessary. Defendant's

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III. *Motion to Alter or Amend Class Certification*

The United States Supreme Court recently determined in the case of *Heckler v. Ringer*, — U.S. —, 104 S.Ct. 2013 (1984), that courts have jurisdiction over claims arising under the Medicare Act only pursuant to 42 U.S.C. § 405(g).[4] For a court to have jurisdiction under section 405(g), the plaintiff must present a claim to the Secretary prior to bringing an action in federal court. *Id.* at 2025. Therefore, the Magistrate determined that in this action the court has jurisdiction only over those members of the class who have presented claims to the Secretary prior to pursuing their claims in court. Second Recommended Ruling at 11. The Magistrate therefore recommended that the class be redefined as follows:

> All persons residing in Health Care Financing Administration Region I (New England), who, have presented their claims to the Secretary for Medicare Part A benefits for inpatient hospital rehabilitation, based upon physician certification of their need for and their receipt of a relatively intense multidisciplinary rehabilitation program with a coordinated team approach to upgrade their ability to function as independently as possible and who have not been awarded such benefits. Second Recommended Ruling at 11-12.

Because the Magistrate's proposed amendment to the definition of the class insures that all class members will satisfy the criteria for standing enunciated in *Ringer*, this court hereby approves the redefinition of the class. Further, for the reasons stated in the Magistrate's Second Recommended Ruling, the court also approves the Magistrate's determination that three of the named plaintiffs, Lucy Anselmo, Theodore Tann, and Margaret Gamble, are no longer members of the class and thus cannot serve as named plaintiffs.

The Secretary has also argued that none of the named plaintiffs may pursue their claims in federal court because they have not exhausted their administrative remedies. The court finds this argument unpersuasive. 42 U.S.C. § 405(g) requires exhaustion of administrative remedies unless the Secretary waives the exhaustion requirement, or the claimant's interest in having his case resolved is so great that waiver of the exhaustion requirement is appropriate. See *Weinberger v. Salfi*, 422 U.S. 749, 766-67 (1975); *Mathews v. Eldridge*, 424 U.S. 319, 330 (1976). The factors to be considered in determining whether a claimant's interest in having a case resolved is so great that waiver of the exhaustion requirement is appropriate are: (1) whether the plaintiff's legal claims are substantially collateral to the demand for benefits; (2) whether exhaustion would be futile; and (3) whether the harm suffered pending exhaustion would be irreparable. *City of New York v. Heckler*, 742 F.2d 729, 736 (2d Cir. 1984) (Newman, J.). See *Eldridge*, 424 U.S. at 330-31; *Ringer*, — U.S. —, 104 S.Ct. at 2020-24. The plaintiffs do not contest the Secretary's claim that the plaintiffs have not exhausted their administrative remedies and that the Secretary has not waived the exhaustion requirement. Rather, plaintiffs contend that their interest in having their claims resolved is so great that a judicial waiver of the exhaustion requirement is appropriate. This court agrees with the Magistrate that, in this instance, judicial waiver is appropriate.

A. *Collateral to Benefits*

In *City of New York v. Heckler*, 742 F.2d 729 (2d Cir. 1984), the plaintiffs, a class of persons with severe mental illness estimated to include more than 50,000 New York residents, challenged an unpublished, informally-adopted administrative procedure utilized by the Social Security Administration that effectively imposed upon the plaintiffs a presumption of ineligibility for original and continuing disability benefits. The court found that the plaintiffs' legal claims were "substantially collateral" to a claim for benefits because what the class complained of was "fundamentally a procedural irregularity," and because "[t]he District Court was not asked to and did not rule on the merits of any of the underlying claims." *City of New York*, 742 F.2d at 737.

As in *City of New York*, the plaintiffs in this case complain of an unpublished, informally-adopted administrative procedure that is "fundamentally a procedural irregularity." Similarly, as was true in *City of New York* and not true in *Ringer*, this court has not been asked to rule on the merits of any of the underlying claims. Compare *City of New York*, 742 F.2d at 737, with *Ringer*, 104 S.Ct. at 2021. If successful in their challenge, plaintiffs will still have to pursue their individual claims through the

(Footnote Continued)

Memorandum in Support of Objections to the Magistrate's [Second] Recommended Ruling at 7-10.

These contentions overlook the fact that Bulletin No. 175 prohibits coverage for inpatient hospital rehabilitative care even where such care has been determined to be medically necessary or where the patient's needs could *not* be met in a skilled nursing facility, unless the patient's condition "also otherwise necessitates" inpatient hospital care. This language clearly establishes criteria in addition to those set forth in the Act, thereby triggering the publication requirements of the FOIA.

[4] See *Ringer*, 104 S.Ct. at 2021-23 (barring federal question and mandamus jurisdiction in claims "arising under" the Medicare Act).

administrative process. Therefore, this court finds that the plaintiffs' claim is substantially collateral to a claim for benefits.

B. Futility of Proceeding Administratively

The court also finds that it would be futile for the plaintiffs to pursue their claims in the administrative forum. As in *City of New York*:

> we discern no legitimate interest to be advanced by requiring plaintiffs to travel through the administrative maze as a prerequisite of a judicial hearing. This is not a case like . . . *Heckler v. Ringer, supra*, where the claim asserted could benefit from further factual development or from the agency's "experience and expertise" . . . . As in *Eldridge* it is not realistic to "expect that the Secretary would consider substantial changes in the current administrative review system at the behest of a single aid recipient . . . in an adjudicatory context" . . . . 742 F.2d at 737 (citations omitted).

The Secretary contends that exhaustion of administrative remedies would not be futile. She supports this contention by noting that subsequent to the filing of this action, three of the named plaintiffs (Anselmo, Tann, and Gamble) received awards of benefits from administrative law judges, and thus, "the remaining plaintiffs and the unnamed class members '[stand] the chance of prevailing in administrative appeals.'" Defendant's Memorandum in Support of Objections to the Magistrate's Recommended Ruling at 23, citing *Ringer*, 104 S.Ct. at 2023, 2028. However, the plaintiffs' claim in this action does not concern benefits, but instead concerns what has already been described as essentially a procedural irregularity. The fact that some members of the original class have been awarded benefits is not evidence of any probability that the plaintiffs may be able to compel the Secretary to invalidate Bulletin No. 175 on the basis of violation of the Freedom of Information Act.

C. Irreparable Injury

To demonstrate irreparable injury, the plaintiffs must make a colorable showing that the ordeal of proceeding through the administrative process would cause them injury for which retroactive benefits would not fully compensate. *City of New York*, 742 F.2d at 736. The Magistrate found that the plaintiffs had demonstrated irreparable injury. The court agrees with the Magistrate's reasoning:

> [These] Medicare recipients are old and infirm by definition. The care that is at issue in this case is "a relatively intense, multidisciplinary rehabilitative program" designed to upgrade the patients' ability to function as independently as possible. The delay attendant to the administrative process, given the age and infirmity of Medicare patients, imposes severe hardship on the claimants. Lack of rehabilitative care may lead to irreversible loss of function and render the review process meaningless. Second Recommended Ruling at 10.

The Secretary points out that the Magistrate's position appears to be that some of the plaintiffs will suffer irreparable injury because they will not undertake to pay for the treatment themselves. The Secretary then takes the position that the inability to pay for treatment is an impermissible consideration, citing *Ringer*. See Defendant's Memorandum in Support of Objections to the Magistrate's Recommended Ruling at 20-22. The *Ringer* Court denied standing to a plaintiff who claimed that he did not go through with treatment because of his inability to pay. However, the plaintiff in *Ringer* was denied standing not because severe financial hardship cannot be a ground for finding an irreparable injury, but because he did not initially present his claim to the Secretary, and thus failed to meet the *nonwaivable* element of standing under section 405(g). Indeed, the Court in *Eldridge* premised its finding of irreparable injury on the claimant's "physical condition and dependency upon the disability benefits." *Eldridge*, 424 U.S. at 331.

In contrast to the plaintiff in *Ringer*, plaintiffs here have incurred liability for the cost of treatment, and have presented their claims to the Secretary, thus satisfying the nonwaivable element of the standing test. Because these plaintiffs are in need of a course of rehabilitative treatment over a period of time, it is likely that they will exhaust their personal resources while the administrative process grinds on. Plaintiffs' inability to continue treatment would result in severe and irreparable injury to them.

Because plaintiffs here have met the nonwaivable standing requirement by presenting their claims to the Secretary, the court finds that *Ringer* is not controlling on the irreparable injury issue and that *Eldridge* permits a finding that plaintiffs' inability to pay for continued treatment constitutes irreparable injury sufficient to support waiver of the exhaustion requirement.

IV. Motion for a More Specific Order

The plaintiffs have moved for an order specifying steps the Secretary must take to implement the Magistrate's and this court's finding that Bulletin No. 175 is invalid. The Magistrate has recommended the following order:

> 1. That the defendant notify all HCFA regional offices, all HCFA Region I intermediaries and all HCFA Region I hospitals that Bulletin No. 175 has been declared invalid by the United States District Court and that it is no longer in effect.

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2. That all HCFA documents which include the coverage criteria found in Bulletin No. 175 are hereby declared void and of no effect.

3. That the defendant notify all HCFA regional officers, all HCFA Region I intermediaries and all HCFA Region I Hospitals that to the extent that HCFA *Intermediary Manual* § 3101.11 incorporates Medicare coverge criteria found in Bulletin No. 175, it is void and of no effect. Second Recommended Ruling at 14-15.

The plaintiffs have offered sufficient evidence to indicate that the Secretary has not taken sufficient steps to rescind the challenged policy statement contained in Bulletin No. 175, and that her officers have placed barriers in front of those making inquiries concerning Bulletin No. 175. Since the Magistrate's order simply gives precise effect to the ruling that Bulletin No. 175 is invalid, it is hereby approved.

The plaintiffs have also requested this court to order the Secretary to notify all Professional Review Organizations (PROs) in Region I that Bulletin No. 175 is invalid. Annette Kasabian, Chief of the Medical Review Branch of the Region I office of the Health Care Financing Administration, stated in her affidavit that "by January 15, 1985, [PROs] . . . will have assumed [all] Medicare review authority over all Medicare certified rehabilitation hospital[s] in Region I." [Second Affidavit of Annette Kasabian.] If the PROs and not the intermediaries are to be the Medicare reviewers of future inpatient hospital rehabilitation, then they should receive notice of the invalidity of Bulletin No. 175 as well. This is particularly true since, according to the plaintiffs, the PRO criteria for rehabilitation hospital coverage adopt the *Intermediary Manual* and Bulletin No. 175 standards.

Therefore, it is ORDERED that the defendant notify all Professional Review Organizations in Region I that: (1) Bulletin No. 175 has been declared invalid by the United States District Court and that it is no longer in effect; (2) that to the extent that HCFA *Intermediary Manual* § 3101.11 incorporates Bulletin No. 175, it is void and of no effect. This court FURTHER ORDERS that all court-ordered notification ordered be completed by the Secretary 90 days from the date of this ruling.

The plaintiffs have also requested that the court require the defendant to notify all claimants who have been denied Medicare coverage for inpatient hospital rehabilitation since January 1, 1976 (when Bulletin No. 175 was issued), or 1980 (when this lawsuit was filed), and to provide an opportunity for a second de novo administrative hearing. Since this request has not been submitted to the Magistrate for consideration, the court declines to rule on this request. The court will refer plaintiffs' request to the Magistrate if the request is made in motion form.

As amplified and modified by the foregoing, the Magistrate's Recommended Ruling on Plaintiffs' Motion for A More Specific Order, Defendant's Motion to Alter or Amend Class Certification, and Defendant's Motion for Reconsideration is accepted and approved.

SO ORDERED.

[¶ 34,620] Community Convalescent Center of Naperville, Incorporated v. Aetna Life and Casualty Company.

PRRB Hearing Dec. No. 85-D25, Mar. 19, 1985 (cost reporting period ending Oct. 31, 1982).

Medicare: Space Costs of Physical Therapy Department

Provider reimbursement—Cost data and cost finding—Cost finding schedules—Allocation of space costs to physical therapy department.—A corridor in the basement of a skilled nursing facility could not be included by the provider in allocating the space costs of its physical therapy department. Even though the provider had claimed that the corridor was used exclusively by physical therapy patients for gait training, substantial evidence demonstrated that the corridor is a common area that affords equal access to all who use it. The weighting proposed by the intermediary, resulting in an allowance of a portion of one-half of the corridor space for the time the physical therapist could have been involved in gait training, was not appropriate according to the averaging principle generally applied under Reg. Sec. 405.453.

See ¶ 6480.

Issue:

Has the Intermediary properly determined the space used by the Physical Therapy Department?

Summary of Facts:

The provider is a skilled nursing facility. The provider filed its cost report for the year ended October 31, 1982, claiming a length of corridor for use by the Physical Therapy Department. In the Notice of Program Reimbursement (NPR)

in federal court as a claim arising under federal law. 28 U.S.C. § 1331 (1982).

We have said that a provider's right to reimbursement results from "a statutory business relationship." *Case v. Weinberger*, 523 F.2d 602, 607 (2d Cir. 1975). Although the relationship may be effectuated by means of a provider contract, all rights to reimbursement arise under the applicable statutes. Just as we held in *Case*, 523 F.2d at 609-10, that some obligations of providers are statutorily determined (e.g., compliance with safety standards), so are a provider's rights statutorily determined, unless those rights are explicitly provided for in the agreement. Having determined the appropriate statute of limitations period, we turn to an analysis of whether there are any triable factual disputes concerning when the claims accrued.

B. No Triable Factual Issues

Because of the three-year limitations period, all claims accruing prior to March 23, 1978 are time-barred. The district court found that all of appellant's claims had accrued before that date. With regard to those claims for improper deductions, Hollander does not dispute that these deductions were made between 1970-76 and that he knew the deductions were made at that time. A claim alleging damages arising from these deductions accrues when notice is provided of the deductions. *Rand v. Brezenoff*, 555 F.Supp. 532, 533 (E.D.N.Y. 1982). Since appellant conceded that he knew of the deductions no later than 1976, the limitations period for the last claim accrued in 1976, and all claims are now time-barred.

With respect to the rejected claims, appellant relies on the Chief Accountant's affidavit. Although certain that the claims had been rejected prior to March 23, 1978 the Chief Accountant could not provide the exact day of notification. Appellant asserts that because the dates of notification are unknown, a factual dispute exists as to whether the claims were processed or rejection notices sent.

Appellant's latest claim could not have been submitted after May 1976. His cause of action accrued on the date that he knew or should have known that the claims were rejected. *Id.* at 533. In *Rand*, the court noted that providers must resubmit their original claims for reimbursement if they have not recevied responses on their initial filings. Failure to receive a response within six months of filing a claim puts a provider on notice of a failure to reimburse, and it then has the burden to either resubmit or refile its claim. *Id.* at 534. At that point, a provider's cause of action for that injury has accrued. *Id.* Thus, six months after submitting its last claim for reimbursement, appellant's cause of action accrued on all claims which were either rejected or for which appellant had received no response. November 1976 is therefore the cut-off date and this action filed in 1981 is untimely.

III. CONCLUSION

The order is affirmed.

[¶ 35,374] Blanche Fox, Representative of the Estate of Walter Fox, et al. v. Bowen.

U.S. District Court, District of Connecticut. Civ. No. H-78-541(JAC), Apr. 23, 1986.

Medicare: Entitlement to Physical Therapy Services

Notices, determinations, and appeals—Exhaustion of administrative remedies—Judicial review of legality of *Intermediary Manual* provisions.—A U.S. district court has jurisdiction to hear beneficiaries' claim that sections of the *Medicare Intermediary Manual* and administration of benefits for skilled physical therapy services under those sections by intermediaries are statutorily and constitutionally deficient. The Secretary of HHS contended that the district court lacked jurisdiction over such an action pursuant to the provisions of 42 U.S.C. Sec. 405(g), which requires that a claimant exhaust administrative remedies before proceeding to federal court.

A U.S. court of appeals has held that judicial waiver of the exhaustion requirement is appropriate where irreparable harm exists, exhaustion would be futile to vindicate procedural rights, and the claim is at least "substantially" collateral to the entitlement to benefits. With respect to irreparable harm, the beneficiaries have raised a colorable claim that recovery of retroactive benefits would not be fully compensatory. Many of the beneficiaries who discontinued their physical therapy prematurely so as not to exhaust their personal financial resources will never be able to achieve as complete a recovery as would have been possible had their benefits not initially been denied. Next, the beneficiaries complain fundamentally of a procedural irregularity and not of the Secretary's substantive standards of eligibility. Therefore, the beneficiaries state a claim that is sufficiently collateral to the benefit claims of its members to permit waiver of the exhaustion requirement. Finally, the beneficiaries have also satisfied the futility requirement because in the instant case, although exhaustion might have resulted in recovery of benefits for some members of the class, the administrative process cannot vindicate the procedural rights asserted in this case. It

is unrealistic to expect the Secretary to consider substantial changes in the current administrative review system at the behest of a single beneficiary.

See ¶ 13,540.035.

Medicare Part A coverage—Extended care services—Skilled physical therapy—Sufficiency of coverage.—The Secretary of HHS's practice of denying skilled physical therapy benefits under Part A of Medicare on the basis of arbitrary presumptions or "rules of thumb" violates Medicare statutes and regulations, and the Due Process Clause of the U.S. Constitution. Under the Secretary's procedures, as outlined in the *Medicare Intermediary Manual*, intermediaries actually awarded coverage to only a small number of patients who demonstrated a rapid recovery of body functions, and even those patients generally received no more than two weeks of coverage.

The applicable regulations and the relevant portions of the *Manual* clearly contemplate that each patient will receive an individualized assessment of his need for daily skilled physical therapy, based on the facts and circumstances of his particular case. It is contrary to the regulations for an intermediary to deny benefits on the basis of informal presumptions or rules of thumb that are applied across the board without regard to the medical conditions or therapeutic requirements of the individual patient. Therefore, the Secretary is enjoined from using arbitrary and inflexible practices in determining a patient's entitlement to physical therapy coverage and is further required to give an individualized evaluation of each patient's medical condition and therapeutic needs.

See ¶ 1325.

[Text of Decision]

Introduction

CABRANES, District Judge: This action challenges practices and procedures that allegedly have been used by the Secretary of the United States Department of Health and Human Services ("the defendant" or "the Secretary")[1] to deny Medicare benefits for physical therapy to a certified class of elderly Connecticut residents ("the plaintiffs").[2]

The plaintiffs contend that the defendant's biased procedures for reviewing Medicare claims and his practice of routinely denying Medicare coverage for certain categories of physical therapy rendered by skilled nursing facilities ("SNFs") violate their rights under Part A of Title XVIII of the Social Security Act ("the Medicare Act"), 42 U.S.C. § 1395-1395xx, and the Due Process Clause of the Fifth Amendment to the United States Constitution. The Medicare Act entitles members of the plaintiff class to payment of the "reasonable and necessary" costs of "post-hospital extended care services for up to 100 days during any spell of illness." 42 U.S.C. §§ 1395d(a)(2), 1395y(a)(1). These services are covered under Part A of Medicare only if the patient receives "skilled nursing care . . . or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis." 42 U.S.C. § 1395f(a)(2)(C).

The Secretary may contract with private organizations (known as "fiscal intermediaries") for assistance in the administration of the Medicare Act.[3] The intermediaries determine the amount of Medicare reimbursement payable to SNFs and other service providers. 42 U.S.C. § 1395h(a). See generally *Kraemer v. Heckler*, 737 F.2d 214, 214-217 (2d Cir. 1984) ("*Kraemer*") (general description of Medicare program). A decision by an intermediary denying coverage under Part A of the Medicare Act is subject to administrative and judicial review. 42 U.S.C. § 1395ff.

The plaintiffs request that the court enjoin and declare illegal the defendant's methods for determining eligibility for physical therapy coverage under Part A of Medicare and impose a new set of procedures in their place. In addition, the plaintiffs ask that the defendant be required

[1] Since the filing of this action, the name of the department of which the defendant is Secretary has been changed to the United States Department of Health and Human Services ("HHS").

[2] The original class consisted of "all Connecticut residents who, pursuant to the policies and practices of the defendants which are challenged herein, have been or will be denied Medicare Part A extended care coverage for physical therapy and rehabilitative services, and whose claims involve an amount in controversy not less than $1,000." See Ruling on Motion for Class Certification (filed May 3, 1983); Ruling on Defendant's Motion for Summary Judgment (filed Aug. 9, 1983) ("*Summary Judgment Ruling*") at 13 n.1. By consent of the parties the definition of the plaintiff class has been narrowed by deletion of the words "or will be" as a result of the holding of the Supreme Court in *Heckler v. Ringer*, 466 U.S. 602 (1984) ("*Ringer*") (in order to meet the non-waivable jurisdictional requirements of 42 U.S.C. § 405(g), a claim must have been presented to the Secretary). See Plaintiffs' Unopposed Motion for Modification of Class Definition (filed April 19, 1985 and granted April 22, 1985); see also *Califano v. Yamasaki*, 442 U.S. 682, 701 (1979) (class actions maintainable pursuant to 42 U.S.C. § 405(g) "so long as the membership of the class is limited to those who meet the requirements of [that section]").

[3] These fiscal intermediaries administer the Medicare Act in Connecticut. See Certified Official Transcript of Trial ("Tr.") at 201. Because the intermediaries are agents of the defendant, their practices are legally imputable to defendant. See *Kraemer v. Heckler*, 737 F.2d 214, 215 (2d Cir. 1984) ("*Kraemer*").

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to reconsider their claims for physical therapy benefits that previously were denied.

Upon a consideration of the full record of this case, including the testimony and exhibits offered at the four-day non-jury trial and the post-trial findings and memoranda submitted by the parties, the court enters the following findings of fact and conclusions of law pursuant to Rule 52(a), Fed. R. Civ. P.

I. Findings of Fact

A. Description of the Plaintiff Class

1. There are approximately 20,000 patients residing in Connecticut's 220 SNFs. Certified Official Transcript of Trial ("Tr.") at 143. The typical patient is in his early to mid-80s. Tr. 143, 313. Many of these patients, perhaps as many as 50 percent, require physical therapy services in the nursing home. Tr. 192, 257.

2. Members of the plaintiff class often receive physical therapy as treatment for strokes, fractured hips, and other broken bones. Tr. 12, 246, 40-41.

3. The typical class member is afflicted with multiple disabilities that may complicate and prolong his rehabilitation. Tr. 50, 283, 311-312, 316. See 42 C.F.R. §409.33(a)(1) (recognizing that patients with multiple disabilities often require more extensive nursing or rehabilitation services than do patients with a single disability).

B. Plaintiffs' Need for Skilled Physical Therapy

4. Physical therapy is a skilled profession. A physical therapist can achieve greater success in the rehabilitation of a patient than can a person who is untrained in physical therapy. Tr. 50, 75, 283-284, 293, 337.

5. Patients vary considerably in the extent and the speed of their response to a program of physical therapy. Tr. 316. See Plaintiffs' Exhibit 26 (*Health Insurance Manual* 13 ["HIM-13"]) at §3101.8B(c), (d). for example, some stroke patients may respond slowly to physical therapy during their first weeks in the nursing home because of the effects of medication and emotional trauma. Tr. 22-24. It is therefore difficult to predict the physical therapy that will be required by a particular patient based on the experience of other patients. Tr. 22-24, 288.

6. The court credits the uncontroverted testimony of the plaintiffs' medical experts that daily skilled physical therapy is often required during each of the following stages of the patient's rehabilitation:

(a) Patients often need daily skilled physical therapy during the "non-weight-bearing" stage of rehabilitation. Tr. 52, 278-279, 285, 315.[4] This is the stage at which the patient cannot place his weight on his injured leg or foot. Such therapy may be necessary, for example, to prevent the patient's joints from stiffening and his muscles from wasting while his injury heals. Tr. 51, 285.

(b) A patient whose arm or leg has been amputated may often require daily skilled physical therapy during the period before he is fitted for a prosthesis. Amputees who do not receive physical therapy during this period may develop wasted stumps and contractures in their hips and may have a more difficult time when therapy eventually is begun. Tr. 84-85.

(c) A patient may require daily skilled physical therapy in order to maintain as well as to increase body strength and function. Tr. 317. For example, a patient with a hip fracture may require daily skilled physical therapy to prevent the remainder of his body from deteriorating during the period in which he is immobilized.

(d) A patient may require daily skilled physical therapy even if he is able to "ambulate" (that is, walk with the assistance of a walker or crutches) for up to 50 feet with supervision. Tr. 318-319.

(e) Passive "range of motion" exercises (that is, exercises in which the affected body part is moved by another person) may require the skilled supervision of a physical therapist on a daily basis. Tr. 73-74, 337.

(f) A patient may require daily skilled physical therapy for a period in excess of two weeks. Tr. 322.

C. Defendant's Practice of Denying Medicare Coverage

7. The defendant grants Medicare coverage for physical therapy to only a small number of patients who demonstrate a rapid recovery of body function. Even these patients generally receive no more than two weeks of coverage. Tr. 13-14, 22, 54, 282, 344.

8. The defendant may deny coverage for daily skilled physical therapy even when such therapy

[4] The defendant's claim that one of the plaintiffs' witnesses testified that "daily" therapy might not have been necessary for a particular patient in the "non-weight-bearing" stage of rehabilitation, see Defendant's Post-Trial Memorandum at 20 & n.7, does not accurately reflect the record, see Tr. 295-298, where the witness stated that daily therapy was ideal and refused to concede that three days of therapy per week would have been adequate. *Id.* In any event, the witness's testimony was addressed to the case of a specific patient rather than to the cases of all patients in the "non-weight-bearing" stage of rehabilitation.

has been ordered by the patient's treating physician. Tr. 33, 239-240.

9. It is the defendant's practice to deny coverage for physical therapy received during the "non-weight-bearing" stage of rehabilitation. Tr. 13, 51-52, 71, 285, 315.

10. It is the defendant's practice to deny coverage for physical therapy administered to amputees who have not yet been fitted with prostheses. Tr. 70-71, 84-85.

11. It is the defendant's practice to deny coverage to patients receiving "maintenance" physical therapy. Tr. 317-318.

12. It is the defendant's practice to terminate coverage for physical therapy when the patient is able to walk with the supervision of an aide. Tr. 18. However, as was established by uncontroverted expert testimony, such patients still may not recover fully unless they receive additional skilled physical therapy on a daily basis. Tr. 18-20, 84.

13. It is the defendant's practice to terminate coverage once the patient is able to ambulate 50 feet with supervision. Tr. 61. However, as was established by undisputed expert testimony, the distance that a patient is able to ambulate with supervision is not, by itself, determinative of his need for daily skilled physical therapy. Tr. 318.

14. It is the defendant's practice to deny coverage for physical therapy that consists of passive "range-of-motion" exercises. Tr. 74-76.

15. The reason typically advanced by an intermediary to justify the denial of Medicare coverage is that the physical therapy required by the patient is not "skilled." Tr. 74-75. However, as was established by credible expert testimony, the intermediaries often deny coverage without giving adequate consideration to the physical therapy skills required in a particular case. Tr. 102, 311, 313, 344.[3]

16. Before acting on a claim, SNF personnel may telephone the intermediary to discuss whether the patient is covered by Medicare. Tr. 28-29, 240-241, 328-329, 220-221. However, the testimony at trial revealed few instances in which these informal communications significantly affected an intermediary's coverage determinations. Tr. 19-21.

D. The Effects on Plaintiffs of Denials of Benefits

17. Skilled physical therapy can enable many elderly patients to leave the nursing home and return to the community to live independently. Tr. 282-284, 313, 315-316. Indeed, as one of the plaintiffs' experts testified credibly, if more elderly persons received skilled physical therapy after sustaining a stroke or fracture, fewer of these persons would have to spend the remainder of their lives in nursing homes. Tr. 316, 326.

18. Patients who are denied Medicare coverage are responsible for paying for their own physical therapy through insurance, personal savings or contributions from family members. Tr. 50, 56, 164, 211. In such circumstances, many patients forgo medically necessary physical therapy because they or their families believe that they cannot afford to pay for such therapy themselves. Tr. 8, 21, 26-27, 43-44, 49-50, 56-57.

19. A patient's recovery may be jeopardized, according to the credible and uncontroverted testimony of the plaintiffs' medical experts, if the patient forgoes medically necessary physical therapy during the weeks immediately following his injury or illness. Tr. 25-27, 56-57, 283-284. In some cases, a patient's recovery is also inhibited by the emotional distress that may result from a denial of Medicare coverage. Tr. 25-26.

20. Accordingly, the denial of medically necessary physical therapy benefits has significant physiological, emotional and financial implications for many members of the plaintiff class.

E. Defendant's Coverage Determination Process

21. The SNF is responsible as an initial matter for determining whether a newly admitted patient is to receive Medicare coverage. Tr. 13, 144, 48; HIM-13 at §3439.1). If the SNF decides that the services to be received by the patient are covered by Medicare, but the intermediary later reverses the SNF's decision, the SNF must absorb the cost of any such services if it "knew, or could be expected to know, that payment for such services ... could not be made" under Part A of Medicare. 42 U.S.C. §1395pp(b), Tr. 64.

22. An SNF that grants a claim for Medicare coverage is required to provide the intermediary with extensive documentation of the patient's medical condition, the services rendered to the patient, and the extent of the patient's recovery.

[3] The defendant claims that one witness's testimony that intermediaries use the term "skill" not as a factual concept but merely "to imply a threshold beyond which they were not prepared to pay" is undermined because the witness did not understand the regulatory definition of "skill." Defendant's Post-Trial Memorandum at 18-19 & n.6. This argument is without merit in view of other testimony by the witness that revealed his understanding that "skilled nursing and skilled rehabilitation services" are defined for purposes of Medicare as services "furnished directly by or under *the supervision of* [personnel such as physical therapists]." 42 C.F.R. §409.31(a)(3) (emphasis supplied). See Tr. 340-341.

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Tr. 212-213; Plaintiffs' Exhibit 21 (Deposition of Jeremiah Flynn, an employee of the defendant ["Flynn Deposition"]) at 10. The intermediary may decide on the basis of this information to reverse the SNF's initial award of coverage to the patient. Tr. 147-148. The SNF may then be liable for the cost of any services erroneously rendered to the patient.

23. However, when the SNF denies a claim for Medicare coverage, the SNF is not required to provide the intermediary with any information concerning the patient's condition (aside from his admitting diagnosis) or the treatment that may have been ordered by the physician or rendered by the SNF. Tr. 214-215; Flynn Deposition at 20-21, 30. The SNF is required to provide additional documentation to the intermediary only if the patient seeks reconsideration of the SNF's denial of benefits. Accordingly, an SNF's denials of coverage are rarely, if ever, questioned by the intermediary unless the patient has requested reconsideration. Tr. 39, 147, 329.

24. The Secretary formerly provided a coverage determination procedure, sometimes called a "presumption of non-liability," whereby the SNF was presumed not to have known or to have had reason to know that the services provided to a patient were not covered under Medicare. The SNF was entitled to this "presumption of non-liability" only if it met a "denial rate criterion" established by the Secretary. HIM-13 §3433. The "denial rate criterion" was satisfied if, of the total number of days of care deemed by the SNF to be covered by Medicare, no more than 5 percent were later denied coverage by the intermediary. HIM-13 §§3433, 3434. An SNF's denial rate would typically rise when one of its decisions to grant coverage was reversed by the intermediary; if its denial rate rose above 5 percent, the SNF would lose its "presumption of non-liability" and would be liable for the cost of any further coverage allowed by the SNF but later denied by the intermediary. Tr. 52, 145-146; HIM-13 §3433. An SNF could at least theoretically have lost its "presumption of non-liability" by erroneously denying coverage in more than 10 percent of its total claims, see HIM-13 §3439.2; however, there was no evidence that an SNF was ever threatened with the loss of its "presumption of non-liability" for denials rather than awards of coverage. The "presumption of non-liability" was eliminated by the Secretary in revised regulations that took effect March 24, 1986. 51 Fed. Reg. 6222 (Feb. 21, 1986).

25. Because SNFs were more likely to lose their "presumption of non-liability" by erroneously granting coverage than by erroneously denying coverage, see Findings of Fact 22-24, *supra*, some SNFs tended to decide "questionable" claims by "erring always on the side of denying, rather than allowing" coverage in order to preserve their "presumption of non-liability." Tr. 148-149, 328.

F. Administrative Review of Denials of Benefits

26. Between January 1, 1977 and September 30, 1979, the number of initial coverage determinations issued by Medicare intermediaries for patients residing in Connecticut nursing homes was 74,815, or 2,267 each month. Plaintiffs' Exhibit 11 (Defendant's Answers to Plaintiffs' First Interrogatories) at 4. Approximately 98 percent of these determinations were denials. Tr. 186, 167; Plaintiffs' Exhibit 15.

27. A substantial percentage of these denials were for physical therapy benefits. For example, a former administrative law judge at the Social Security Administration Office of Hearings and Appeals in Hartford, Connecticut, who ruled on approximately 300 Medicare cases between 1972 and 1982, testified credibly that approximately 250 of these cases concerned claims for SNF coverage in which physical therapy was an "important component." Tr. 95. He granted additional coverage in 75 percent to 80 percent of the physical therapy cases; typically, he gave the claimants "most, if not all" of the relief that they had requested. Tr. 102-104.

28. In addition, the record contains two surveys of cases in which initial denials of Medicare coverage to SNF patients were appealed by Legal Assistance to Medicare Patients. Of these 303 cases, 292, or 58 percent, involved claims for physical therapy. Tr. 237, 192; Plaintiffs' Exhibits 14, 20. Of the 292 cases in which physical therapy coverage had been denied, 82 percent were eventually reversed on appeal to the intermediary, the Secretary or a federal district court. Tr. 193, 239; Plaintiffs' Exhibit 20.

29. Few denials of Medicare coverage for SNF services are ever appealed. For example, in the period from January 1, 1977 to September 30, 1979, only 2.4 percent of all SNF initial determinations were appealed for reconsideration by the intermediary and only 0.3 percent were taken to a subsequent hearing before an administrative law judge. Defendant's Answer to Plaintiffs' Interrogatories at 5, 6 (Plaintiffs' Exhibit 12, 13). The failure of many SNF patients to appeal their denials of benefits is attributable in significant part to their age and ill health. Tr. 184, 344-345. See also *David v. Heckler*, 591 F.Supp. 1033, 1044 (E.D.N.Y. 1984) (Weinstein, C.J.) (taking judicial notice that "numerous erroneous determinations [of Medicare Part B benefits] are not appealed" because of "the difficulty of the elderly in dealing with bureaucratic hurdles").

30. It often takes more than a year to appeal a denial of Medicare benefits. For example, the family of one of the plaintiffs waited sixteen

months between his initial denial in November 1977 and the Secretary's decision granting benefits in March 1979. Plaintiff's Exhibit 1 (Transcript in Case of Walter Frat). This delay is not atypical. Plaintiffs' Exhibits 14, 20.

II. Conclusions of Law

A. Jurisdiction

As a threshold matter, the defendant, relying on the decision of the Supreme Court in *Heckler v. Ringer*, 466 U.S. 602 (1984) ("*Ringer*"), contends that the court lacks jurisdiction over this action pursuant to 42 U.S.C. § 405(g).[4]

Section 405(g) requires that a claimant exhaust administrative remedies before proceeding in federal court. See *Ringer, supra*, 466 U.S. at 617. There are two requirements for exhaustion under Section 405(g): First, there is the so-called "nonwaivable" requirement that a claim for benefits previously must have been presented to the Secretary. See *id.*; *Mathews v. Eldridge*, 424 U.S. 319, 328 (1976); *City of New York v. Heckler*, 742 F.2d 729, 735 (2d Cir. 1984) (Newman, J.) ("*City of New York*"), aff'g 578 F.Supp. 1109 (E.D.N.Y. 1984) (Weinstein, C.J.), *cert. granted*, 105 S.Ct. 57 (1985). There can be no doubt that the members of the plaintiff class, who by definition have had claims for Medicare benefits denied by the Secretary, have satisfied the presentment requirement. See *Ringer, supra*, 466 U.S. at 617; *City of New York, supra*, 742 F.2d at 735; Plaintiffs' Memorandum in Response to Defendant's Memorandum on the Significance of *City of New York v. Heckler* (filed Jan. 7, 1985) at 3-4 (describing defendant's denial of plaintiffs' claims); Recommended Ruling on Motion to Dismiss (filed Dec. 19, 1979) ("Motion to Dismiss Ruling") (Eagan, M.) at 3 *adopted by endorsement ruling* (entered Dec. 26, 1979) (Clarie, C.J., to whom this case originally was assigned).

Second, there is the so-called "waivable" requirement that a claim for benefits must have been fully pursued at the administrative level. See *Ringer, supra*, 466 U.S. at 617; *City of New York, supra*, 742 F.2d at 735. This exhaustion requirement may be dispensed with by the courts in appropriate circumstances. See *Ringer, supra*, 466 U.S. at 618; *City of New York, supra*, 742 F.2d at 736.

The circumstances in which such "judicial waiver" of the exhaustion requirement may be appropriate were described by our Court of Appeals in *City of New York*, a case decided after *Ringer*. The court held that

> [t]he Supreme Court has adopted a practical approach to section 405(g)'s exhaustion requirement. The Court has approved judicial waiver where plaintiff's legal claims are collateral to the demand for benefits, where exhaustion would be futile, or where the harm suffered pending exhaustion would be irreparable. . . . In the absence of express guidance [from the Supreme Court as to whether futility, collaterality and irreparable harm must all be present for judicial waiver of the exhaustion requirement], we have taken the view that no one factor is critical. [citation omitted] We have adopted a more general approach, balancing the competing considerations to arrive at a just result under the circumstances presented. *City of New York, supra*, 742 F.2d at 736.

In that case, which involved a challenge to an improper presumption used by the Secretary to determine eligibility for Social Security disability benefits, the Court of Appeals held that judicial waiver was appropriate where irreparable harm existed, exhaustion would have been futile to vindicate procedural rights and the claim was at least "substantially" collateral to the entitlement to benefits. *Id.* at 736-737. The court will consider the application of each of these three criteria to the facts of the instant case.

First, with respect to the issue of irreparable harm, the court holds that in the instant case, as in *City of New York, supra*, 742 F.2d at 736, the "claimants have raised a colorable claim that recovery of retroactive benefits would not be fully compensatory." Many of the plaintiffs who discontinued their physical therapy prematurely so as not to exhaust their personal financial resources will never be able to achieve as complete a recovery as would have been possible had their benefits not initially been denied. See Findings of Fact 19, 20. Moreover, for some of

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[4] 42 U.S.C. § 405(g) provides, in pertinent part:

> Any individual, after any final decision of the Secretary made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Secretary may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia.

This section is made applicable to the Medicare Act by 42 U.S.C. § 1395ff.

The defendant previously (and unsuccessfully) challenged the court's jurisdiction over this action. See Recommended Ruling on Motion to Dismiss (filed Dec. 19, 1979) (Eagan, M.) at 2-3, *adopted by endorsement ruling* (entered Dec. 26, 1979) (Clarie, C.J., to whom this case originally was assigned). To the extent that the applicable law has changed since the denial of defendant's motion to dismiss, the issue of subject matter jurisdiction properly may be ascertained at this juncture. See Rule 12(h)(3), Fed. R. Civ. P. However, to the extent that the same legal criteria are still relevant, the earlier ruling is the law of the case.

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the plaintiffs in the instant case, as for some of the plaintiffs in *City of New York*, "the trauma of having ... benefits cut off" may itself have "trigger[ed] a severe medical setback" that cannot be cured by an eventual award of benefits. 578 F. Supp. at 1118. See Findings of Fact 19, 20. Finally, the court has found in the instant case, as the district court found in *City of New York*, that "[b]ecause of their disability, many members of the [plaintiff] class were incapable of challenging the bureaucracy," 578 F.Supp. at 1118, and therefore were unable to avoid the permanent loss of their benefits. See Finding of Fact 29.

Second, the court holds that the claims of the plaintiff class are at least "substantially" collateral to the benefit claims of the individual class members. See *City of New York, supra*, 742 F.2d at 737. The instant case is clearly distinguishable in this respect from *Ringer, supra*, 466 U.S. at 615-616, where the Court found that the respondents were merely claiming that they should be reimbursed for certain surgical procedures and that, if the respondents prevailed, "only essentially ministerial details will remain before [they] would receive reimbursement." The court has previously concluded in the instant case, however, that the "planitiffs do not allege that use of a new eligibility standard will automatically entitle them to benefits or physical therapy." Motion to Dismiss Ruling at 4-5. See *generally David v. Heckler*, 591 F.Supp. at 1039 ("[t]he instant case is distinguishable [from *Ringer*] since plaintiffs seek prospective relief against a continuing illegal practice rather than specific benefits").

It is true that the plaintiffs' challenge to the defendant's practice of denying Medicare coverage for certain categories of physical therapy is not wholly collateral to the plaintiffs' individual claims for benefits. However, this claim is similar to the claim of the plaintiffs in *City of New York*, that was held to be "substantially" collateral to their claims for benefits and therefore to "present an appropriate circumstance for waiver." 742 F.2d at 737. In *City of New York*, the plaintiffs argued that the Secretary employed an across-the-board presumption instead of making the required individualized determination of each claimant's eligibility for disability benefits; in the instant case, the plaintiffs argue that the Secretary denies Medicare benefits on the basis of informal "rules of thumb" that fail to take into account each claimant's individualized need for the daily skilled physical therapy to which he is entitled under the applicable statute and regulations. Accordingly, the court holds that in this case, as in *City of New York*, "the [plaintiff] class ... complains fundamentally of a procedural irregularity and not of the Secretary's substantive standards of eligibility," *id.* at 737, and therefore has stated a claim that is sufficiently collateral to the benefit claims of its members to permit waiver of the exhaustion requirement.

Finally, the court holds that the plaintiffs have also satisfied the futility requirement because in the instant case, as in *City of New York, supra*, 742 F.2d at 737, "[a]lthough exhaustion might have resulted in recovery of ... benefits for some members of the class, as was also true in [*Mathews v. Eldridge*], the administrative process cannot vindicate the procedural rights asserted in this litigation." It would be just as unrealistic in this case as it was in *Mathews v. Eldridge* and *City of New York* to "expect that the Secretary would consider substantial changes in the current administrative review system at the behest of a single aid recipient ... in an adjudicatory context." *Mathews v. Eldridge, supra*, 424 U.S. at 330; *City of New York, supra*, 742 F.2d at 737. There is no evidence in the instant case that the Secretary has "consider[ed] substantial changes" in his procedures for evaluating claims for physical therapy benefits despite the frequency with which his initial denials of such benefits have been reversed by administrative law judges and federal district courts. See Findings of Fact 27, 28. Indeed, the aged and infirm have been offered no assurance that the Secretary will ever consider such changes no matter how many more denials of physical therapy benefits are reversed on appeal.

Accordingly, after "balancing the competing considerations [of futility, collaterality and irreparable harm] to arrive at a just result under the circumstances presented," *City of New York, supra*, 742 F.2d at 736, the court concludes that the plaintiffs have met the waivable as well as the nonwaivable requirements for jurisdiction pursuant to 42 U.S.C. § 405(g). It is therefore unnecessary to consider the planitiffs' claim that the court may also exercise mandamus jurisdiction over this action pursuant to 28 U.S.C. § 1361.

B. Merits

The plaintiffs make two claims on the merits. First, they allege that the intermediaries' practice of routinely denying allegedly meritorious claims for physical therapy coverage violates applicable statutes and regulations. Second, they claim that the defendant's former "waiver of liability" procedure is impermissibly biased because it has encouraged SNFs to deny allegedly meritorious claims. It is asserted that these practices, alone and in combination, have deprived the plaintiffs of a protected property interest without due process of law in violation of the Fifth Amendment to the United States Constitution.

72-699 O - 87 -- 6

1. The Intermediaries' Practice of Denying Physical Therapy Claims

The testimony at trial established a practice on the part of the intermediaries of denying physical therapy benefits under Part A of Medicare for maintenance therapy, for non-weight-bearing therapy administered to fracture patients, for passive "range-of-motion" activities, for patients who can ambulate 50 feet with supervision and for amputees who have not been fitted with prostheses. See Findings of Fact 9, 10, 11, 12. The testimony also established that the intermediaries generally allow Medicare coverage for no more that than two weeks of physical therapy. See Finding of Fact 8. The court holds for the following reasons that these practices deny patients coverage for skilled physical therapy that otherwise might be covered by Medicare, see Finding of Fact 6, and are contrary to the applicable law and regulations. The high rate of reversal of intermediary denials, see Findings of Fact 27, 28, is indicative of the incorrectness of the intermediaries' practices.

The Secretary has promulgated regulations with respect to the physical therapy services covered by Medicare. See 42 C.F.R. § 409.30-409.36.[7] In addition, he has published a

[7] The court, rejecting various challenges by the plaintiffs, previously has upheld the validity of the defendant's regulations. Summary Judgment Ruling at 4-10.

42 C.F.R. § 409.31 provides, *inter alia*:

(a) *Definition.* As used in this section, "skilled nursing and skilled rehabilitation services" means services that:

(1) Are ordered by a physician;

(2) Require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and

(3) Are furnished directly by, or under the supervision of, such personnel.

(b) *Specific conditions for meeting level of care requirements.*

(1) The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.

* * *

(3) The daily skilled services must be ones that, as a practical matter, can only be provided in a SNF, on an inpatient basis.

42 C.F.R. § 409.32 provides:

(a) The service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.

(b) A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually non-skilled (such as those listed in § 409.33(d)) may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel. . . .

(c) The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. . . .

42 C.F.R. § 409.33 provides, *inter alia*:

(a) *Services that could qualify as either skilled nursing or skilled rehabilitation services—*

(1) *Overall management and evaluation of care plan.* The development, management, and evaluation of a patient care plan based on the physician's orders constitute skilled services when, because of the patient's physical or mental condition, these activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety. This would include the management of a plan involving only a variety of personal care services when, in light of the patient's condition, the aggregate of these services requires the involvement of technical or professional personnel. For example, an aging patient with a history of diabetes mellitus and angina pectoris who is recovering from an open reduction of a fracture of the neck of the femur requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, an exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his or her condition or complications resulting from restricted, but increasing mobility. Although any of the required services could be performed by a properly instructed person, such a person would not have the ability to understand the relationship between the services and evaluate the ultimate effect of one service on the other. Since the nature of patient's condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure that patient's recovery and safety. Under these circumstances the management of the plan of care would require the skills of a nurse even though the individual services are not skilled. Skilled planning and management activities are not always specifically identified in the patient's clinical record. Therefore, if the patient's overall condition would support a finding that recovery and safety can be assured only if the total care is planned, managed, and evaluated by technical or professional personnel, it would be appropriate to infer that skilled services are being provided.

(2) *Observation and assessment of the patient's changing condition.* Observation and assessment constitute skilled services when the skills of a technical or professional person are required to identify and evaluate the patient's need for modification of treatment or additional medical procedures until his or her condition is stabilized. . . . Likewise, surgical patients transferred from a hospital to a skilled nursing facility while in the complicated unstabilized post-operative period, *e.g.*, after a hip prosthesis or cataract surgery, may need continued close skilled monitoring for post-operative complications, and adverse reaction . . .

* * *

(c) *Services which would qualify as skilled rehabilitation services.*

(1) Ongoing assessment of rehabilitation need and potential: Services concurrent with the management of a patient care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders.

(2) Therapeutic exercises or activities: Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the patient, must be performed

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Health Insurance Manual 13 ("HIM-13"), which is intended to guide intermediaries in determining whether individual claims for payment are to be covered by Medicare.[4] The appli-

(Footnote Continued)

by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the patient and the effectiveness of the treatment;

(3) Gait evaluation and training: Gait evaluation and training furnished to restore function in a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality;

(4) Range of motion exercises: Range of motion exercises which are part of the active treatment of a specific disease state which has resulted in the loss of, or restriction of, mobility (as evidenced by a therapist's notes showing the degree of motion lost and the degree to be restored);

(5) Maintenance therapy: Maintenance therapy, when the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance . . .

• • •

(d) *Personal care services.* Personal care services which do not require the skill of qualified technical or professional personnel are not skilled services except under the circumstances specified in § 409.32(b). Personal care services include, but are not limited to, the following:

• • •

(13) General supervision of exercises which have been taught to the patient; including the actual carrying out of maintenance programs. *I.e.*, the performance of the repetitive exercises required to maintain function do not require the skills of a therapist and would not constitute skilled rehabilitation services (see paragraph (c) of this section). Similarly, repetitious exercises to improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities, which are not related to a specific loss of function; and assistive walking do not constitute skilled rehabilitation services.

42 C.F.R. § 409.34 provides, *inter alia:*

(a) To meet the daily basis requirement specified in § 409.31(b)(1), the following frequency is required:

(1) Skilled nursing services or skilled rehabilitation services must be needed and provided 7 days a week; or

(2) *As an exception,* if skilled rehabilitation services are not available 7 days a week, these services must be needed and provided at least 5 days a week.

[4] Summary judgment was granted in favor of defendant on the issue of whether HIM-13 was promulgated in violation of applicable statutes and federal regulations. See Summary Judgment Ruling at 14.

HIM-13 § 3101.8 provides, in pertinent part:

A. *General.*—To be covered physical therapy services the services must relate directly and specifically to an active written treatment regimen established by the physician after any needed consultation with the qualified physical therapist and must be reasonable and necessary to the treatment of the individual's illness or injury.

B. *Reasonable and Necessary.* To be considered reasonable and necessary the following conditions must be met:

(a) The services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition,

(b) the services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under his supervision. Services which do not require the performance or supervision of a physical therapist are not considered reasonable or necessary physical therapy services, even if they are performed or supervised by a physical therapist. (When the intermediary determines the services furnished were of a type that could have been safely and effectively performed only by a qualified physical therapist or under his supervision, it should presume that such services were properly supervised. However, this assumption is rebuttable and if in the course of processing claims, the intermediary finds that physical therapy services are not being furnished under proper supervision, the intermediary should deny the claim.)

(c) There must be an expectation that the condition will improve significantly in a reasonable (and generally predictable) period of time based on the assessment made by the physician of the patient's restoration potential after any needed consultation with the qualified physical therapist or the services must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state, and

(d) The amount, frequency, and duration of the services must be reasonable.

• • •

1. *Restorative Therapy.* To constitute physical therapy a service must, among other things, be reasonable and necessary to the treatment of the individual's illness. If an individual's expected restoration potential would be insignificant in relation to the extent and duration of physical therapy services required to achieve such potential, the physical therapy would not be considered reasonable and necessary. In addition, there must be an expectation that the patient's condition will improve in a generally predictable period of time. However, if at any point in the treatment of an illness, it is determined that the expectations will not materialize, the services will no longer be considered reasonable and necessary; and they, therefore, should be excluded from coverage under [42 U.S.C. § 1395y(a)(1)].

2. *Maintenance Program.* The repetitive services required to maintain function generally do not involve complex and sophisticated physical therapy procedures, and consequently the judgment and skill of a qualified physical therapist are not required for safety and effectiveness. However, in certain instances the specialized knowledge and judgment of a qualified physical therapist may be required to establish a maintenance program. For example, a Parkinson patient who has not been under a restorative physical therapy program may require the services of a physical therapist to determine what type of exercises will contribute the most to maintain the patient's present functional level.

In such situations the initial evaluation of the patient's needs, the designing by the qualified physical therapist of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient or supportive personnel, *e.g.*, aides or nursing personnel or family members where physical therapy is being furnished on an outpatient basis in carrying out the program and such subsequent

cable regulations and the relevant portions of HIM-13 clearly contemplate that each patient will receive an individualized assessment of his need for daily skilled physical therapy based on the facts and circumstances of his particular case.

For example, the regulations authorize coverage for physical therapy "exercises or activities which, because of the *type of exercises employed* or the *condition of the patient*, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the patient and the effectiveness of the treatment." 42 C.F.R. § 409.33(c)(2) (emphasis added). The regulations similarly provide that maintenance physical therapy will qualify for Medicare coverage "when the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance program *based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance*." 42 C.F.R. § 409.33(c)(5) (emphasis added). The regulations likewise allow coverage for "[r]ange of motion exercises which are part of the active treatment of a specific disease state which has resulted in a loss of, or restriction of, mobility (as evidenced by a therapist's notes showing *the degree of motion lost and the degree to be restored*)." 42 C.F.R. § 409.33(c)(4) (emphasis added).

It is clearly contrary to such regulations for an intermediary to deny benefits on the basis of informal presumptions, or "rules of thumb," that are applied across the board without regard to the medical condition or therapeutic requirements of the individual patient. *Cf. City of New York, supra*, 742 F.2d at 732-733 (enjoining administrative practice of employing a presumption in Social Security disability determinations that was inconsistent with applicable law).

This is not to say that all or even most of the class members who were denied coverage for physical therapy as a result of the intermediaries' inflexible and arbitrary practices ought to have received coverage. However, the Secretary cannot permit his intermediaries to use blanket rules not supported or authorized by any applicable law or regulations to deny what otherwise might be meritorious claims.

The various arguments offered by the Secretary in support of the intermediaries' practices are unpersuasive and unsupported by the record of this case. In his Post-Trial Memorandum (filed July 13, 1984) at 20 & n.7, the Secretary argues that physical therapy benefits are not available for patients in the "non-weight bearing" stage of rehabilitation and for amputees who have not yet received prostheses, because such patients do not require daily therapy and because Part B of Medicare may provide coverage for three days a week of therapy for patients who have purchased this optional health insurance. For one thing, the intermediaries' presumption that such patients never require skilled physical therapy on a daily basis is

(Footnote Continued)

reevaluations as may be required would constitute physical therapy.

Where a patient has been under a restorative physical therapy program, the physical therapist should regularly be reevaluating the condition and adjusting any exercise program in which the patient is engaged. Consequently, when it is determined that no further restoration is possible, the physical therapist should have already designed the maintenance program required and instructed the patient, supportive personnel (or family members where physical therapy is being furnished on an outpatient basis) in the carrying out of the program. Therefore, where a maintenance program is not established until after the restorative physical therapy program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage under [42 U.S.C. § 1395y(a)(1)].

C. *Application of Guidelines.* The following discussion illustrates the application of the above guidelines to the more common modalities and procedures utilized in the treatment of patients:

• • •

2. *Gait Training.* Gait evaluation and training furnished a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality requires the skills of a qualified physical therapist. However, if gait evaluation and training cannot reasonably be expected to improve significantly the patient's ability to walk, such services would not be considered reasonable and necessary. Repetitious exercises to improve gait or maintain strength and endurance and assistive walking, such as provided in support for feeble or unstable patients, are appropriately provided by supportive personnel, *e.g.*, aides or nursing personnel, and do not require the skills of a qualified physical therapist.

• • •

4. *Range of Motion Tests.* Only the qualified physical therapist may perform range of motion tests and, therefore, such tests would constitute physical therapy.

5. *Therapeutic Exercises.* Therapeutic exercises which must be performed by or under the supervision of the qualified physical therapist . . . due either to the type of exercise employed or to the condition of the patient would constitute physical therapy. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease which has resulted in a loss or restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored) and such exercises, either because of their nature [or] the condition of the patient, may only be performed safely and effectively by or under the supervision of a qualified physical therapist. Generally, range of motion exercises which are not related to the restoration of a specific loss of function but rather are related to the maintenance of function (see B.2) do not require the skills of a qualified physical therapist.

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inconsistent with the uncontroverted testimony of the plaintiffs' medical experts. See Finding of Fact 6. For another, the defendant's argument that partial coverage of a given service under Part B of Medicare somehow forecloses full coverage of that service under Part A of Medicare appears to conflict with the regulatory requirement that, in determining whether skilled nursing or rehabilitation services can "as a practical matter" be provided only by an SNF, "the availability of Medicare payment for those services may not be a factor." 42 C.F.R. § 409.35(a).

In addition, the Secretary contends that any conflict between the plaintiffs' experts and the intermediaries with respect to the need of a given category of patient for daily skilled physical therapy is nothing more than a "*bona fide* professional difference of opinion." Defendant's Post-Trial Memorandum at 16 & n.5. However, the only evidence offered by the defendant in support of this proposition, see Tr. 75-76, is limited to the question of whether coverage ought to be provided for range-of-motion exercises. The defendant has offered no evidence of any "*bona fide* professional difference of opinion" concerning non-weight-bearing therapy, maintenance therapy, therapy for amputees who are awaiting prostheses or therapy for patients who can ambulate 50 feet with supervision. Furthermore, even assuming for the argument that some professional difference of opinion exists with respect to range-of-motion exercises, the regulations expressly provide coverage for such exercises whenever they are "part of the active treatment of a specific disease state which has resulted in a loss of, or restriction of, mobility." 42 C.F.R. § 409.33(c)(4).

Finally, the defendant maintains that the intermediaries' denials of coverage cannot be characterized as arbitrary because employees of an intermediary sometimes are available to discuss individual coverage decisions with employees of an SNF. See Finding of Fact 16; Defendant's Post-Trial Memorandum at 16-17 & n.5. However, in the absence of any evidence in the record that these discussions have caused intermediaries to alter their coverage decisions in more than isolated instances, see *id.*, the court cannot find that these occasional informal communications between SNFs and their intermediaries afford the plaintiffs the individualized determinations of their eligibility for skilled physical therapy to which they are entitled under the applicable regulations.

In order to determine whether the intermediaries' improper denial practices violate the Due Process Clause of the Fifth Amendment, the court must apply the balancing test enunciated by the Supreme Court in *Mathews v. Eldridge*, *supra*, 424 U.S. at 335. That test requires the court to consider three distinct factors:

> [f]irst, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail. See *Kraemer*, *supra*, 737 F.2d at 221 (applying *Mathews v. Eldridge* balancing test in due process challenge to Secretary's "presumption of non-liability" procedure).

The private interest at stake in this action is highly significant. A denial of a Medicare claim for physical therapy benefits has important physiological, psychological, and financial implications for the plaintiffs. See Findings of Fact 17-20. As the Court of Appeals held in *Kraemer*, which also involved the denial of Medicare benefits to SNF patients, the private interest in such cases is particularly great because the costs of SNF care "can financially cripple all but the very wealthy" in a matter of weeks and "diminish[] the probability that a patient could choose to continue receiving medical care." 737 F.2d at 222.

The risk that the plaintiffs will erroneously be deprived of their Medicare benefits is great indeed, as is demonstrated by the high percentage of decisions denying physical therapy coverage that are reversed on appeal. See Findings of Fact 27-28. In addition, many other patients with potentially meritorious claims are physically or mentally incapable of pursuing an administrative appeal. See Finding of Fact 29. See also *David v. Heckler*, *supra*, 591 F.Supp. at 1044 (holding that even a 33 percent reversal rate established a "substantial" risk that plaintiffs would be erroneously deprived of Medicare Part B benefits and that "numerous erroneous determinations [denying benefits] are not appealed"). It is clear that additional safeguards will significantly reduce the risk that members of the plaintiff class will continue to be erroneously deprived of their benefits.

Finally, alternative procedural safeguards designed to ensure that Medicare coverage determinations are made on the basis of the individual patient's medical condition and therapeutic requirements, rather than on the basis of arbitrary and inflexible presumptions, see Section IIC, *infra*, will entail no greater "fiscal and administrative burdens" for the government than are contemplated by the applicable law and regulations. Furthermore, these safeguards, by ensuring that members of the plaintiff class receive the medically necessary

physical therapy to which they may be entitled under Medicare, may actually reduce the "fiscal burdens" on the federal and state treasuries by enabling more elderly persons to live independently outside nursing homes. See Finding of Fact 17.

Accordingly, for the reasons stated above, the court concludes that the defendant's practices of determining eligibility for skilled physical therapy benefits under Part A of Medicare violate the Due Process Clause of the Fifth Amendment.[9]

2. The Secretary's Procedures for Reviewing SNF Coverage Decisions

The plaintiffs also contend that the Secretary's "presumption of non-liability," see Findings of Fact 23, 24, has caused the SNFs' initial determinations of Medicare coverage to be impermissibly biased against the granting of benefits. In support of this claim, the plaintiffs have offered testimony that some SNF personnel have tended in "questionable" situations to "err[] always on the side of denying, rather than allowing" coverage in order to preserve their "presumption of non-liability." See Finding of Fact 24.

The Secretary has since the conclusion of this trial promulgated regulations that terminated the "presumption of non-liability" effective March 24, 1986. See 51 Fed. Reg. 6222. Accordingly, the plaintiffs' challenge to the Secretary's "presumption of non-liability" procedure must be deemed moot.

It appears that the new regulations have not eliminated certain other practices that were criticized by the plaintiffs in connection with their challenge to the "presumption of non-liability." For example, the intermediaries presumably may continue to scrutinize SNFs' awards of coverage more thoroughly than SNFs' denials of coverage. See Findings of Fact 22, 23. However, the record contains insufficient evidence to persuade the court that the Secretary's current procedures for reviewing SNF coverage determinations operate in a manner that is impermissibly biased against the members of the plaintiff class.

Moreover, to the extent that the SNFs may have felt undue pressure in the past to deny arguably meritorious claims for physical therapy coverage, any such pressure is likely to be reduced substantially as a result of the remedy to be provided in this action. It is to this question that the court now turns.

C. Relief

The issue of relief has not been extensively briefed by the parties to this action. However, the plaintiffs have suggested that the Secretary be required to adopt a presumption of Medicare coverage whenever the patient's treating physician prescribes a program of daily physical therapy; the Secretary could rebut this presumption, according to the plaintiffs, by offering substantial evidence (based on more than a "paper record") that the services prescribed by the physician are not covered by Medicare. The court finds that such a procedure is unsupported by any statutory or regulatory authority and is likely to saddle the government with "fiscal and administrative burdens" beyond those that would be appropriate under the balancing test of *Mathews v. Eldridge*; indeed, the effect of such a procedure could be to permit doctors to dispense Medicare benefits without the constraints of intermediary review.

Although the plaintiffs are not entitled to the remedy that they have requested, they are entitled to some relief. Accordingly, an order shall enter declaring unlawful the intermediaries' improper practices of denying claims for physical therapy benefits, enjoining the future use of such practices and instructing the Secretary properly to supervise determinations of physical therapy coverage made by his intermediaries. Members of the plaintiff class whose claims were denied based on practices of the intermediaries that have been found to be unsupported by applicable regulations, see Section IIB(1), *supra*, and who have not prevailed on appeal, are entitled to reconsideration of their claims. See generally *City of New York*, *supra*, 742 F.2d at 739-740.

The parties shall confer and submit to the court, by no later than June 20, 1986, a proposed judgment effectuating this decision. The proposed judgment shall include a description of the procedure that is to be used by the Secretary in reconsidering the plaintiffs' claims for benefits.

Conclusion

The court has jurisdiction over this action pursuant to 42 U.S.C. §405(g). The plaintiffs are entitled to judgment with respect to their challenge to the intermediaries' improper practices of evaluating claims for physical therapy benefits under Part A of Medicare. The plaintiffs' challenge to the defendant's "presumption of non-liability" has been rendered moot by the defendant's termination of that procedure. By

[9] The plaintiffs, relying on *Jones v. Califano*, 576 F.2d 12 (2d Cir. 1978), also raise an equal protection claim asserting that those elderly people who appeal their denials of Medicare coverage ultimately receive benefits while those who do not appeal are permanently deprived of coverage. Although the court need not reach this claim in light of its disposition of the plaintiffs' due process challenge to the defendant's coverage determination procedures, the court notes in passing that *Jones v. Califano* is clearly distinguishable both legally and factually from the case at bar.

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no later than June 20, 1986, the parties shall submit a proposed judgment consistent with this decision together with any appropriate orders and supporting memoranda.

It is so ordered.

[¶ 35,373] Fifty Residents of Park Pleasant Nursing Home v. Commonwealth of Pennsylvania.

Pennsylvania Commonwealth Court. No. 2905 C.D. 1984, Jan. 10, 1986.

Before: ROGERS, MACPHAIL, Judges, and BARBIERI, Senior Judge.

Medicaid: Level-of-Care Change

Pennsylvania—Notice, hearing, and appeals concerning benefit—Level-of-care change—Adequacy of agency notice.—Even though agency regulations forming the basis for the reduction in the level of care rendered to fifty nursing residents are valid, agency determinations reducing the residents' level of care are reversed since notices sent to those residents of the recommended reduction were inadequate under both federal and state regulations. First, no reason was given for the intended reductions in each of the residents' level of care and no specific regulations supporting the recommendations were cited. Further, references to the agency's regulations that were listed in the notice concerned inspection of care procedures, not the definitions of skilled care which were relied upon in making the recommendations. Finally, the notice was devoid of detail and contained no explanation of the basis for the proposed level-of-care reduction.

See ¶ 14,765.15, 14,765.41, 15,632.

[Text of Decision]

ROGERS, Judge: This is the appeal of fifty nursing home residents of the Park Pleasant Nursing Home (residents) who have been receiving skilled nursing care under the Medical Assistance Program.[1] Following an annual inspection, the Pennsylvania Department of Public Welfare's (DPW) Inspection of Care team recommended that the care of the appellant residents be reclassified from skilled to intermediate. DPW sent notices to the residents recertifying them in accordance with the recommendation. The residents appealed this determination, and two days of hearings were held at which the hearing officer upheld DPW's recommendations. The hearing officer's decision was affirmed by DPW's Office of Hearings and Appeals. The residents filed a request for reconsideration which was denied by DPW's Executive Deputy Secretary. The residents have filed a petition for review of the order of recertification, asking us to remand their cases for reevalulation because, as they assert, DPW's procedures were contrary to law and its own regulations.

The residents first claim that the DPW regulations which formed the basis for the reduction in the level of care to them must be invalidated since "[these] regulations examine only the treatment and services provided in determining whether care is skilled or not." The DPW regulations classify skilled care services as follows:

II. Skilled Care Services.

(a) For an individual service provided to the recipient to be considered a skilled care service, the service must:

(i) Be needed by the patient on a daily basis.

(ii) Be ordered by a physician.

(iii) Require the skills of, and be provided either directly by or under the supervision of, medical professionals.

(iv) Be provided to the patient on a daily basis.

(v) Be one that can only be provided, as a practical matter, in a skilled nursing facility on an inpatient basis.

(vi) Be documented in the recipient's medical record daily.

(vii) Be included and not excluded as a skilled care service in the Skilled Nursing Care Assessment Handbook. 55 Pa. Code § 1181, Appendix E II(a).

The residents claim that these criteria do not allow for an analysis of the patient's condition as a whole, which has been found to be necessary by those courts interpreting a similar provision defining "skilled nursing facility services" in the Social Security Act, which states in pertinent part:

[T]he term "skilled nursing facility services" means services which are or were

[1] Title XIX of the Social Security Act (Medicaid), 42 U.S.C. § § 1396-1396p. The Medicaid program is a cooperative federal-state arrangement, and states such as Pennsylvania which choose to participate must comply with the requirements of the Social Security Act and regulations promulgated thereunder.

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April 21, 1987

Senator John Melcher, Chairman
United States Senate Special Committee on Aging
G-33-Dirkson Office Building
Washington, D.C. 20510

Attention: David Schulke

Dear David:

Thank you for your kind note involving the January 11, 1987 judgement in Fox v. Bowen. I include a copy of the judgement here, together with a brief memo describing its significance. Let me know how I can assist further.

Yours truly,

Charles C. Hulin
Attorney at Law

CCH:ewd

Enclosure

MEMORANDUM RE: SIGNIFICANCE OF THE JUDGEMENT ISSUED IN FOX V. BOWEN ON JANUARY 13, 1987.

Jose A. Cabranes, U.S. District Court Judge for the District of Connecticut, has issued a detailed Judgement to effectuate the Memorandum of Decision and Order entered in Fox v. Bowen, (Civil Action No. H-78 541)(JAC), on April 23, 1986. In the April 23rd Memorandum, Judge Cabranes ruled that the Medicare administration's practice of arbitrarily denying Medicare skilled nursing facility coverage to Connecticut's residents requiring daily physical therapy treatments violates the Medicare statute and regulations and the due process clause of the United States Constitution.

The recent Judgment, filed on January 13, 1987, provides for both retroactive and prospective relief. Every living member of the Plaintiff class, including those patients denied Medicare nursing home coverage as early as October 1978, will be notified of the Court's ruling by first-class mail, and offered the opportunity to request a good-faith, individualized redetermination of their entitlement to coverage, free from the arbitrary rules of thumb and presumptions formerly used by the federal government to deny benefits.

In its Judgment the District Court provides for the appointment of a Special Master to oversee Medicare's nursing home coverage determination process. Subsequent to the entry of the Judgement, the Court appointed yale Law School Professor Robert A. Burt to be the Special Master. Professor Burt will conduct a training seminar for all Connecticut intermediary and provider personnel during which he will explain the rulings of the court, including the requirement that beneficiaries receive an individualized assessment of their entitlement to skilled nursing facility benefits.

Following the completion of the training seminar, Professor Burt will receive copies of all redeterminations issued by Medicare fiscal intermediaries for members of the Plaintiff class (Connecticut residents who received daily physical therapy treatments in skilled nursing facilities), as well as copies of all initial coverage determination issued by skilled nursing facilities during a six month trial period. In addition, Professor Burt will undertake an in-depth analysis of randomly selected cases on a sample basis to determine whether the rulings of the Court have been properly implemented. This analysis will include examination of the actual medical record in the sample cases. Professor Burt is also empowered to interview patients, nursing home personnel, and attending physicians, concerning the sample cases he selects.

After the six month trial period is completed, Professor Burt will report to the Court concerning whether the government has

reformed its decision-making process so that patients receive individualized assessments of their entitlement to coverage made in accordance with the Medicare statute and regulations.

Implementation of the new Judgment in Fox should have revolutionary implications for patients seeking Medicare skilled nursing facility coverage. The Health Care Financing Administration, the federal agency which administers the Medicare program, will be required to disclose the decision-making process in hundreds, or even thousands of cases. If the coverage decisions rendered are arbitrarily unfair (as they have usually been in the past) that fact will be clearly revealed to the Special Master and to the Court. If the Health Care Financing Adminstration fails to reform its decision-making process, further, and more drastic, court remedies are likely.

[¶ 36,030] Blanche Fox, Representative of the Estate of Walter Fox, et al. v. Bowen.

U.S. District Court, District of Connecticut. Civ. No. H-78-541 (JAC). Jan. 13, 1987.

Medicare: Entitlement to Physical Therapy Services

Medicare Part A coverage—Extended care service—Skilled physical therapy—Sufficiency of coverage.—Inasmuch as it was previously determined that the Secretary of HHS and his agents acted illegally by arbitrarily denying Medicare skilled nursing facility benefits to patients receiving daily physical therapy treatment between October 1978 and April 1986, the Secretary must grant retroactive and prospective relief to the class of beneficiaries involved. Therefore, the Secretary must give written notice to all living members of the beneficiary class of their right to request that their claims for Medicare skilled nursing facility benefits be redetermined. In addition to a personalized notice by first class mail, the Secretary must publish a generalized notice to the beneficiary class in five newspapers or other publications having general distribution within the State of Connecticut, at least two of which must be publications whose target audience is the elderly. Further, the Secretary must provide written notice to all providers and intermediaries of the judgment of the court, and a special master is appointed to assist in administering and evaluating the relief herein ordered.

See ¶ 1325.

For a related matter between these same parties, see 1986-2 Transfer Binder ¶ 35,374.

[Text of Judgment]

The court hereby enters the following judgment to effectuate the Memorandum of Decision and Order entered in this case on April 23, 1986.

I. *Retroactive Relief To The Plaintiff Class*

A. The defendant will give written notice to all living members of the plaintiff class of their right to request that their claims for Medicare skilled nursing facility benefits be redetermined. The precise method of notification (including, but not limited to separate notice, or notice

[8] We express no opinion concerning Woodstock's due process argument. We leave it to the district court to consider that issue in the first instance.

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included as part of a periodic Medicare Part B notice) is left to the defendant's discretion, provided, however, that such notice be by first class mail and contain a response sheet and a stamped, self-addressed envelope to facilitate reply.

B. In addition to the personalized notice described above, the defendant will publish a generalized notice to the plaintiff class in five newspapers or other publications having general distribution within the State of Connecticut, at least two of which must be publications whose target audience is the elderly.

C. The notice to plaintiffs described above shall inform plaintiffs that:

1. The United States District Court in *Fox v. Bowen*, Civil Action No. H 78-541 (JAC), has determined that the Secretary of Health and Human Services and his agents have acted illegally between October 1978 and April 1986 by arbitrarily denying Medicare skilled nursing facility benefits to patients receiving daily physical therapy treatments.

2. Any Connecticut resident who was denied Medicare skilled nursing facility benefits between October 1978 and the present, despite his or her receipt of daily physical therapy treatments, is a member of the plaintiff class, and is entitled to have his or her claim redetermined by the defendant.

3. Any member of the plaintiff class, or his or her representative, desiring such a redetermination should indicate that fact on the response sheet enclosed with the notice, and return the response sheet to the defendant in the self-addressed envelope enclosed.

D. The response sheet shall indicate the plaintiff's name and address, the name of the skilled nursing facility and the dates of skilled nursing facility care at issue.

E. In making the redetermination, the defendant will ensure that every plaintiff receives an individualized assessment of his or her entitlement to Medicare skilled nursing facility coverage in accordance with the Memorandum of Decision issued by the court on April 23, 1986. Specifically, the defendant will adhere to the following norms.

1. The defendant will not employ arbitrary presumptions or rules of thumb in order to deny coverage; such presumptions include the defendant's practice of denying skilled nursing facility coverage:

a. to patients requiring maintenance therapy;

b. for non-weight bearing therapy administered to fracture patients;

c. for passive "range of motion" activities;

d. for patients who can ambulate 50 feet with supervision;

e. for amputees who have not been fitted with prostheses;

f. for those patients who require daily skilled physical therapy for a period in excess of two weeks.

2. The certification and orders of the attending physician will be given due consideration. In any redetermination where the defendant denies Medicare skilled nursing facility coverage despite the attending physician's certification and order that daily physical therapy be given, the defendant shall describe with particularity why the care involved is not covered by the Medicare program.

F. Copies of all redetermination decisions shall be sent to plaintiffs' counsel, and to the special master described in Section II. C. below.

II. *Prospective Relief*

A. The defendant will provide written notice to all skilled nursing facility providers ("providers") of services and all intermediaries, informing them that:

1. The United States District Court in *Fox v. Bowen*, Civil Action No. H 78-541 (JAC), has determined that the Secretary of Health and Human Services and his agents have acted illegally between October 1978 and 1986 in arbitrarily denying Medicare skilled nursing facility benefits to patients receiving daily physical therapy treatments.

2. In making such determinations, providers and intermediaries shall henceforth ensure that every plaintiff receive an individualized assessment of his or her entitlement to Medicare skilled nursing coverage. Specifically, providers and intermediaries will adhere to the following norms:

a. Providers and intermediaries will not employ arbitrary presumptions or rules of thumb to deny coverage; such presumptions include providers' and intermediaries' practice of denying skilled nursing facility coverage:

1. to patients requiring maintenance therapy;

2. for non-weight bearing therapy administered to fracture patients;

3. for passive "range of motion" activities;

4. for patients who can ambulate 50 feet with supervision;

5. for amputees who have not been fitted with prostheses; and

6. for those patients who require daily skilled physical therapy for a period in excess of two weeks.

b. The certification and orders of the attending physician will be given due consideration. In any determination where the provider or intermediary denies Medicare skilled nursing facility coverage despite the attending physician's certification and order that daily physical therapy be given, the provider or intermediary shall describe with particularity why the care involved is not covered by the Medicare program.

3. Providers will supply the special master described below with copies of all coverage determination notices (either denial notices or claims for coverage) issued by providers for members of the plaintiff class. In addition, the providers will supply the special master in every case with an information sheet containing the patient's primary and secondary diagnoses, and indicating the frequency of physical therapy treatments ordered by the patient's attending physician.

B. The court shall appoint a special master to assist in administering and evaluating the relief provided by this Judgment. On or before the 15th day following the date of this Judgment, the parties shall submit, jointly or separately, the names and qualifications of individuals willing to undertake the duties of special master specified in this Judgment. After such nominations by the parties, the court shall issue an Order appointing a special master.

C. The special master shall have the following duties:

1. The special master shall conduct a seminar for all intermediary and provider personnel in Connecticut. At the seminar, the special master will explain the rulings of the court, including the requirement that all members of the plaintiff class receive an individualized assessment of their entitlement to skilled nursing facility benefits.

2. The special master will receive copies of all skilled nursing facility coverage determination notices (either denial notices or claims for coverage) issued by providers for members of the plaintiff class, together with the additional information set forth in Section II(A)(3) above.

3. The special master will choose a random sample of claim denials for further analysis, such method of selection and frequency thereof to be at the reasonable discretion of the special master. For purposes of such further analysis, the special master will obtain copies of the pertinent medical record and, at his or her discretion, may interview personnel of the provider, the plaintiff involved, and the attending physician, as appropriate, to determine whether plaintiffs are receiving the individualized determinations called for by this Judgment and other rulings of the court.

4. The special master will receive copies of all redetermination decisions, as set forth in Section II(F) above.

5. All documentary material collected by the special master will be made available for inspection by the parties.

6. After the special master has collected the information specified above for a period of six months, the special master will submit a formal written report to the court, with copies to counsel, detailing the special master's findings, which shall include the proportion of grants and denials of Medicare coverage for plaintiffs receiving daily physical therapy treatments (with respect to redeterminations in accordance with Section I and determinations with respect to Section II), and stating whether, in the special master's opinion, the plaintiff class as a whole is receiving individualized determinations as called for by the rulings of the court.

D. After receipt of the special master's written report, the court will schedule an evidentiary hearing at which the special master will be available for examination, if requested by either or both of the parties or by the court. After such hearing, the court may issue such further orders as are appropriate or necessary in the circumstances.

E. The special master shall be compensated for services at the rate of $40 per hour, such compensation to be included in recoverable costs under Fed. R. Civ. P. 54(d). In no event shall compensation exceed the amount of $5,000.

It is so ordered.

[¶ 36,031] GAO Report on the Needs of the Elderly in Relation to Rising Federal Costs.

General Accounting Office Report. No. GAO/HRD-86-135, September 30, 1986. Subject: "Meeting the Needs of the Elderly While Responding to Rising Federal Costs."

Medicare/Medicaid: Elderly Needs and Health Care Costs

Medicare and Medicaid—Health care costs of the elderly—Catastrophic illness insurance.—Over the next several years, programs for the elderly could come under increasing review

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Item 8

March 13, 1987

The Honorable John Melcher
U. S. Senate
Room G-233 Dirksen Senate Office Building
Washington, DC 20510

RE: January 26, 1987 Hearing -
U. S. Senate Special Committee on Aging

Dear Senator Melcher:

Because of the delay in getting a copy of the Harvard Report and its length, it has been some time since I promised to supply you with some information. But first of all, we want to thank you for the opportunity you gave the health insurance industry to contribute to your committee's examination of the catastrophic health insurance needs of the elderly.

The following information is in response to your request:

1. A copy of the National Association of Insurance Commissioners' model act regarding standards for long-term care policies along with a draft model regulation implementing this model act. The model act has been finalized by the NAIC while the model regulation is in the process of being reviewed by the NAIC.

2. Some information regarding long-term care policies currently available. This information was gathered by an industry advisory committee as a part of their report to the NAIC which addressed the market development of long-term care insurance.

3. A copy of the Buyer's Guide for Medicare Supplement policies. This Buyer's Guide is required to be given to purchasers of Medicare Supplement policies.

4. A copy of a page out of a paper developed by Carol Kelly, formerly of H.H.S. which provides some information regarding the affordability of long-term care insurance for the elderly. It should be noted that her paper assumed a premium of $450 per year. The reasons that this premium is considerably lower than

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the $1,200 which is mentioned later in this letter are because it represents the premium at age 65 as opposed to the premium for the composite of all ages above 65, benefits are limited to $40 per day as opposed to providing for full charges, and benefits are limited to care received in a skilled nursing facility.

Additional insight regarding affordability of private long-term care insurance is gained by comparing an average premium (e.g., $1,200) with income figures contained in "Aging America, Trends and Projections" prepared by your committee. For example, page 41 shows that the median income in 1984 for persons age 65 and over was $7,349. Table 3-1 graphically displays distributions by level of income and I presume that more definitive data was available to support this graph. I am also attaching a table which shows a distribution of income by size, age, and sex for 1983.

You also asked for some information regarding the cost of long-term care insurance, especially if there was a spend-down deductible provision. In response, I have gathered some information which might be helpful in giving you a rough idea of the costs involved.

The figures that I found are for the year 1984. These figures show the following expenditures in 1984 for people aged 65 and over for nursing home charges:

Total Charges	$25,105,000,000
Portion Paid by Patients (Out-of-Pocket). . . .	12,569,000,000
Portion Paid by Private Insurance and Other Private Sources.	469,000,000
Portion Paid by Medicare.	539,000,000
Portion Paid by Medicaid.	10,418,000,000
Portion Paid by Other Govt. Programs.	1,110,000,000

Since there were approximately 28.5 million persons over age 65 in 1984, this means that the total cost of nursing home care per person over age 65 was approximately $880 in 1984. Since the average cost per stay in a nursing home was around $22,000, a $2,000 deductible would still leave $20,000 out-of-pocket. In other words, it would reduce the cost that would have to be met by some insurance program by 2/22 or 9%. Since the cost per person was $880, a $2,000 deductible would reduce this to $800. This means that an average insurance premium to cover nursing home costs after a $2,000 deductible would cost $800 for claims and possibly another $400 for marketing and administrative expenses, making the total premium $1,200.* This is a rough estimate of the average premium if all 28.5 million participated in a program that paid 100% of charges in excess of $2,000 without limit. Actually, premiums would probably vary by age at issue and reflect the impact of some underwriting selection and limitations on daily benefit levels.

*This is for individual insurance. Group policies would involve lower expenses and premiums.

All of these figures are based on 1984 data and would have to be adjusted upward for the inflation that has taken place since that time.

I have reviewed the Harvard report entitled "Medicare: Coming of Age, A Proposal for Reform" and find that it discusses many avenues for controlling Medicare costs that call for additional analysis and possibly testing of their practicality. Here, increasing price competition among providers might have been included.

Regarding proposed changes in Medicare's benefit structure, I believe they may have overlooked the fact that the vast majority of the elderly have supplemental insurance via private plans or Medicaid. Further, their suggestion that Medicare be expanded to cover annual physical exams should be supported by studies of their impact on health rather than assumptions. Also, the statement that private Medicare Supplement plans duplicate Medicare benefits is false as I stated at your hearing.

I believe their concerns regarding the viability of private long-term care insurance are unfounded. First, their statement that younger citizens are unwilling to purchase such insurance is not supported by any study and is made at a time when citizens have misunderstandings regarding Medicare benefits for this care. Second, private plans cover home health care contrary to their statement. Finally, the report overlooks the funding of private insurance on a group basis which entails minimal administrative expense.

One final observation is that the report does not make suggestions that would help the aged file claims under the Medicare program. From personal experience, I suspect that few of the elderly understand the claim filing system and this creates problems for them. One solution would be to require all providers to file the claims for their Medicare patients.

Senator Melcher, again we appreciate the opportunity to present the views of the health insurance industry and want you to know that you should feel free to call on us if we can be of further service in this matter.

Sincerely yours,

Robert B. Shapland
Vice President and Actuary

028718/mm
Encls.

ATTACHMENT FIVE

Draft: 12/9/86

LONG-TERM CARE INSURANCE MODEL ACT

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Section 1. Purpose

The purpose of this Act is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance as defined from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

Comments: The purpose clause evidences legislative intent to protect the public while recognizing the need to permit flexibility and innovation with respect to long-term care insurance coverage.

Section 2. Scope

The requirements of this Act shall apply to policies delivered or issued for delivery in this state on or after the effective date of this Act. This Act is not intended to supersede the obligations of entities subject to this Act to comply with the substance of other applicable insurance laws insofar as they do not conflict with this Act, except that laws and regulations designed and intended to apply to medicare supplement insurance policies shall not be applied to long-term care insurance. A policy which is not advertised, marketed or offered as long-term care insurance or nursing home insurance need not meet the requirements of this Act. This Section makes clear that entities subject to the Act must continue to comply with other applicable insurance legislation not in conflict with this Act.

Section 3. Short Title

This Act may be known and cited as the "Long-Term Care Insurance Act."

Comments: This section is self-explanatory.

Section 4. Definitions

Unless the context requires otherwise, the definitions in this section apply throughout this Act.

A. "Long-Term Care Insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis, for one or more necessary or medically necessary diagnostic, preventive,

therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual policies or riders whether issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations or any similar organization. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

B. "Applicant" means:

(1) in the case of an individual long-term care insurance policy, the person who seeks to contract for benefits, and

(2) in the case of a group long-term care insurance policy, the proposed certificate holder.

C. "Certificate" means, for the purposes of this Act, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

D. "Commissioner" means the Insurance Commissioner of this state.

Drafting Note: Where the word "Commissioner" appears in this Act, the appropriate designation for the chief insurance supervisory official of the state should be substituted.

E. "Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this state and issued to:

(1) One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations; or

(2) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

(a) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

(b) Has been maintained in good faith for purposes other than obtaining insurance; or

(3)

An association or to a trust or to the trustee(s) of a fund established, created, or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the Commissioner that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and by-laws which provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members, (ii) except for credit unions, the association or associations collect dues or solicit contributions from members, and (iii) the members have voting privileges and representation on the governing board and committees. Thirty (30) days after such filing the association or associations will be deemed to satisfy such organizational requirements, unless the Commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

(4) A group other than as described in subsections E(1), E(2) and E(3), subject to a finding by the Commissioner that:

(a) The issuance of the group policy is not contrary to the best interest of the public;

(b) The issuance of the group policy would result in economies of acquisition or administration; and

(c) The benefits are reasonable in relation to the premiums charged.

F. "Policy" means, for the purposes of this Act, any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer, fraternal benefit society, nonprofit health, hospital, or medical service corporation, prepaid health plan, health maintenance organization or any similar organization.

Drafting Note: This Act is intended to apply to the specified group and individual policies, contracts, and certificates whether issued by insurers, fraternal benefit societies, non-profit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations, or any similar organization. In order to include such organizations, each state should identify them in accordance with its statutory terminology or by specific statutory citation. Depending upon state law, insurance department jurisdiction, and other factors, separate legislation may be required. In any event, the legislation should provide that the particular terminology used by these plans and organizations may be substituted for, or added to, the corresponding terms used in this Act. The term "regulations" should be replaced by the terms "rules and regulations" or "rules" as may be appropriate under state law.

The definition of "long-term care insurance" under this Act is designed to allow maximum flexibility in benefit scope, intensity and level, while assuring that the purchaser's reasonable expectations for a long-term care insurance policy are met. The Act is intended to permit long-term care insurance policies to cover either diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, or any combination thereof, and not to mandate coverage for each of these types of services. Pursuant to the definition, long-term care insurance may be either a group or individual insurance policy or a rider to such a policy, e.g., life, or accident and sickness. The language in the definition concerning "other than an acute care unit of a hospital" is intended to allow payment of benefits when a portion of a hospital has been designated for, and duly licensed or certified as a long-term care provider or swing bed.

Section 5. Limits of Group Long Term Care Insurance

No Group Long Term Care Insurance Coverage may be offered to a resident of this state under a group policy issued in another state to a group described in E(4), unless this state or another state having statutory and regulatory Long Term Care Insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met.

Section 6. Disclosure and Performance Standards for Long-Term Care Insurance

A. The Commissioner may adopt regulations that include standards for full and fair disclosure setting forth the manner, content, and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, pre-existing conditions, termination of insurance, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions of terms.

Comments: This subsection permits the adoption of regulations establishing disclosure standards, renewability and eligibility terms and conditions, and other performance requirements for long-term care insurance. Regulations under this subsection should recognize the developing and unique nature of long-term care insurance and the distinction between group and individual long-term care insurance policies.

B. No long-term care insurance policy may:

(1) Be cancelled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder; or,

(2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.

C. Pre-existing Condition:

(1) No long-term care insurance policy or certificate shall use a definition of "pre-existing condition" which is more restrictive than the following: Pre-existing condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment, or a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within the limitation periods specified in (a) and (b) below:

(a) 6 months preceding the effective date of coverage of an insured person who is 65 years of age or older on the effective date of coverage; or

(b) 24 months preceding the effective date of coverage of an insured person who is under age 65 on the effective date of coverage.

(2) No long-term care insurance policy may exclude coverage for a loss or confinement which is the result of a pre-existing condition unless such loss or confinement begins with the periods specified in (a) or (b) below:

(a) 6 months following the effective date of coverage of an insured person who is 65 years of age or older on the effective date of coverage; or

(b) 24 months following the effective date of coverage of an insured person who is under 65 on the effective date of coverage.

(3) The commissioner may extend the limitation periods set forth in subsections 5(C)(1) and (2) above as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(4) The definition of "pre-existing condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards.

Comments: The definition of pre-existing condition is consistent with the requirement of Section 5 of the NAIC Model Regulation to implement the Individual Accident and Sickness Insurance Minimum Standards Act. Companies now selling long-term care insurance generally use much shorter pre-existing condition periods than those authorized, in part for business

and competitive reasons. It is not anticipated that competitive forces would permit significant lengthening of such periods.

D. Prior Institutionalization:

No long-term care insurance policy which provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than thirty (30) days after discharge from the institution.

E. The Commissioner may adopt regulations establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation.

F. Right to Return - Free Look Provision:

(1) Individual long-term care insurance policyholders shall have the right to return the policy within ten (10) days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. Individual long-term care insurance policies shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within ten (10) days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

(2) A person insured under a long-term care insurance policy issued pursuant to a direct response within thirty (30) days of its delivery and to have the premium refunded if, after examination, the insured person is not satisfied for any reason. Long-term care insurance policies issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page or attached thereto stating in substance that the insured person shall have the right to return the policy within thirty (30) days of its delivery and to have the premium refunded if after examination the insured person is not satisfied for any reason.

6. An outline of coverage shall be delivered to an applicant for an individual long-term care insurance policy at the time of application for an individual policy. In the case of direct response solicitations, the insurer shall deliver the outline of coverage upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. Such outline of coverage shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions and limitations contained in the policy;

E. Affordability of Long Term Care Insurance

The potential affordability of long term care insurance to the elderly has been projected by ICF, Inc. in a study performed under contract to the DHHS Office of the Assistant Secretary for Planning and Evaluation (1985). Based on data from the Census Bureau's 1981 Current Population Survey, ICF, Inc. estimated that between 47-81% of elderly aged 65-69 could potentially afford to purchase a long term care policy similar to that currently being offered by Fireman's Fund. The estimated cost of such a policy if purchased at that age would be $450 per individual per year. The lower bound of the estimate is based on the assumption that this cost would represent less than 5% of cash income annually for those elderly having at least $3,000 in assets. The upper bound represents those elderly having at least $3,000 in assets for whom such premium payments would represent less than 10% of annual cash income. On behalf of the Brookings Institution, ICF is currently updating its analysis of the elderly's available income and assets in relation to need for long term care services using data from the 1982 Long Term Care Survey. These analyses should provide valuable indicators of the potential for adverse selection on the part of the elderly who have the financial means to purchase LTC insurance.

F. Elderly's Interest in Long Term Care Insurance

Finally, a number of data sets are available which provide information on the elderly's interest in and motivations for purchasing LTC insurance. One such dataset whose existence is not widely known consists of a nationwide survey of 2016 non-institutionalized Medicare beneficiaries conducted in October, 1982. (La Tour et. al, in press.) Respondents were given standard HCFA descriptions of

Section 7. Administrative Procedures

Regulations adopted pursuant to this Act shall be in accordance with the provisions of (cite section of state insurance code relating to the adoption and promulgation of rules and regulations or cite the state's administrative procedures act, if applicable).

Comments. This section is self-explanatory.

Section 8. Severability

If any provision of this Act or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Act and the application of such provision to other persons or circumstances shall not be affected thereby.

Comments: This section is self-explanatory.

Section 9. Effective Date

This Act shall be effective (insert date).

NAIC LTC ADVISORY COMMITTEE
EXPOSURE DRAFT

LONG-TERM CARE INSURANCE MODEL REGULATION
DECEMBER 7, 1986

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Section 1. Purpose

The purpose of this regulation is to implement (cite section of law which sets forth the NAIC Long-Term Care Insurance Model Act), to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance as defined from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the Commissioner under (cite sections of law enacting the NAIC Long-Term Care Insurance Model Act and establishing the Commissioner's authority to issue regulations).

Section 3. Applicability and Scope

Except as otherwise specifically provided, this regulation applies to all long-term care insurance policies delivered or issued for delivery in this state on or after the effective date hereof, by insurers, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans, health maintenance organizations and all similar organizations.

Drafting Note: The regulation, like the Model Act, is intended to apply to policies, contracts, subscriber agreements, riders and endorsements whether issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations and all similar organizations. In order to include such organizations, regulations should identify them in accordance with statutory terminology or by specific statutory citation. Depending upon state law and regulation, insurance department jurisdiction, and other factors, separate regulations may be required. In any event, the regulation should provide that the particular terminology used by these Plans, organizations and arrangements (e.g., contract; policy; certificate; subscriber; member;) may be substituted for, or added to, the corresponding terms used in this regulation.

Section 4. Definitions

For the purpose of this regulation, the terms long-term care insurance, group long-term care insurance, commissioner, applicant, policy and certificate shall have the meanings set forth in Section 3 of the NAIC Long-Term Care Insurance Model Act.

Drafting Note: Where the word "Commissioner" appears in this regulation, the appropriate designation for the chief insurance supervisory official of the state should be substituted. To extent that the model act is not adopted, the full definition of the above terms contained in that model act should be incorporated in this section.

Section 5. Policy Definitions and Terms

No policy may be advertised, solicited or issued for delivery in this state as long-term care insurance unless the definitions of terms set forth below, if used in the policy, conform to the requirements of this section.

A. "Medicare" shall be defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Laws 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act," as then constituted and any later amendments or substitutes thereof" or words of similar import.

B. "Mental or Nervous Disorder" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

C. "Skilled Nursing Care", "Intermediate Care", "Personal Care", "Home Care", and other services shall be defined in relation to the level of skill required, the nature of the care, and the setting where care must be delivered.

D. "Skilled Nursing Facility", "Extended Care Facility", "Intermediate Care Facility", "Convalescent Nursing Home", "Personal Care Facility", "Home Care Agency", and other providers of services shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the facility be appropriately licensed or certified.

Drafting Note: State laws relating to nursing and other facilities and agencies are not uniform. Accordingly, specific reference to or incorporation of the individual state law may be required in structuring each definition.

Comments: This section is intended to specify required definitional elements of several terms commonly found in long-term care insurance policies, while allowing some flexibility in the definitions themselves.

Section 6. Policy Practices and Provisions

A. Renewability: The terms "conditionally renewable", "guaranteed renewable", and "noncancellable" shall not be used in any individual long-term care insurance policy, without further explanatory language in accordance with the disclosure requirements of Section 7. No such policy issued to an individual shall contain renewal provisions less favorable to the insured than "conditionally renewable".

1. The term "conditionally renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, except that the insurer may revise rates on a class basis and may decline to renew by class, by geographic area or for stated reasons other than age or deterioration of health.

2. The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

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3. The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

B. Limitations and Exclusions: No policy may be delivered or issued for delivery in this state as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

1. Pre-existing conditions or diseases;

2. Mental or nervous disorders, however this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;

3. Alcoholism and drug addiction;

4. Illness, treatment or medical condition arising out of:

a. war or act of war (whether declared or undeclared);

b. participation in a felony, riot or insurrection;

c. service in the armed forces or units auxiliary thereto;

d. suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or

e. aviation;

5. Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services provided by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance; or

6. Territorial limitations.

Other provisions of this regulation shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described pre-existing diseases, physical condition or extra hazardous activities. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page.

D. Extension of Benefits: Termination of long-term care insurance coverage shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the coverage was in force and continues without interruption after termination. Such

extension of benefits beyond the period the coverage was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period.

Section 7. Required Disclosure Provisions

A. Individual long-term care insurance policies shall contain a renewal, continuation, or nonrenewal provision. The language or specifications of such provision must be consistent with the type of policy issued. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

B. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured or exercises a specifically reserved right under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

C. A long-term care insurance policy which provides for the payment of benefits based on standards described as "usual and customary", "reasonable and customary" or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

D. If a long-term care insurance policy or certificate contains any limitations with respect to pre-existing conditions, such limitations must appear as a separate paragraph of the policy or certificate and be labeled as "Pre-existing Condition Limitations".

E. Right to Return - Free Look Provision:

1. Individual long-term care insurance policies shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within ten (10) days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

2. Long-term care insurance policies issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page or attached thereto stating in substance that the insured person shall have the right to return the policy within thirty (30) days of its delivery and to have the premium refunded if after examination the insured person is not satisfied for any reason.

Section 8. Requirements for Replacement

A. Individual and direct response solicited long-term care insurance application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and sickness or long-term care insurance policy presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

B. Upon determining that a sale will involve replacement, an insurer, or its agent, other than an insurer using direct response solicitation methods shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One (1) copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by (Company Name) Insurance Company. Your new policy provides ten (10) days within which you may decide without cost whether you

desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (pre-existing conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application. Failure to include all material medical and other information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____

DATE

_____

(Applicant's Signature)

C. Insurers using direct response solicitation methods shall deliver the notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

According to (your application) (information you have furnished) you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by (Company Name) Insurance Company. Your new policy provides thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. (To be included only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (Company Name and Address) within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____

(Company Name)

Optional Rating Provision

Benefits under individual long-term care insurance policies shall be deemed reasonable in relation to premiums provided the anticipated loss ratio is at least 55% for conditionally renewable policies, 50% for guaranteed renewable policies, and 45% for noncancellable policies. In evaluating the anticipated loss ratio, due consideration shall be given to all relevant factors, including:

1. Statistical credibility of incurred claims experience and earned premiums;

2. The period for which rates are computed to provide coverage;

3. Experienced and projected trends;

4. Concentration of experience within early policy duration;

5. Expected claim fluctuation;

6. Experience refunds, adjustments or dividends;

7. Renewability features;

8. All appropriate expense factors;

9. Interest;

10. Experimental nature of the coverage;

11. Policy reserves;

12. Mix of business by risk classification; and

13. Product features such as long elimination periods, high deductibles and high maximum limits.

Drafting Note: This optional rating provision is designed to serve as a benchmark for those states deciding to use loss-ratios to determine reasonableness of benefits in relation to premiums.

From June 86
Exposure DRAFT
NAIC LTC Industry Advisory Comm.

APPENDIX B

COMPARISON OF POLICY PROVISIONS

AND BENEFITS FOR A NUMBER OF LONG TERM CARE

INSURANCE CONTRACTS

COMPARISON OF LONG TERM CARE POLICIES

CARRIER	AARP/PRUDENTIAL	AETNA	AIG
SKILLED NURSING CARE			
DAILY BENEFIT	$40	$40	$50
TIME LIMITATION	3 years	4 years	5 years
RESTRICTIONS	stay begins w/in 30 days of a 3 day hospital stay or w/in 30 days of a previous stay	stay begins within 30 days of a 3 day hospital stay must be confined in an SNF	stay begins w/in 30 days of a 3 day hospital stay
INTERMEDIATE CARE			
DAILY BENEFIT	$40	$40	$50
TIME LIMITATION	3 yrs lifetime (all types)	4 years	5 years
RESTRICTIONS	stay begins w/in 30 days of a 3 day hospital stay or w/in 30 days of a previous stay	stay begins after a 120 day SNF stay must be confined in an SNF	stay begins w/in 30 days of a 3 day hospital stay
CUSTODIAL CARE			
DAILY BENEFITS	$40	$40	$50
TIME LIMITATION	3 yrs lifetime (all types)	4 years	5 years
RESTRICTIONS	stay begins w/in 30 days of a 3 day hospital stay or 30 days of a previous stay	stay begins after a 120 day SNF stay must be confined in an SNF	stay follows a 14 day period where skilled or int. care rec. for same/related cond. begins w/in 30 days of SNF/ICF confinement
HOME HEALTH			
DAILY BENEFIT	$25	$20	$50
TIME LIMITATION	365 visits	2 years	2 years
RESTRICTIONS	service must begin w/in 14 days of a 3 day hospital or nursing facility stay	service begins after a 120 day SNF stay	service must begin w/in 30 days of a 30 day covered confinement for sk., int., or cust. care.
ELIMINATION PERIOD	20 days	20 or 100 days	0, 20, or 100 days
$ MAXIMUMS (if any)		Lifetime - $73,000	

COMPARISON OF LONG TERM CARE POLICIES

CARRIER	AARP/PRUDENTIAL	AETNA	AIG
EXTENSIONS	during continuous confinement		during continuous confinement
PRE EXISTING EXCLUSION	6 mos/6 mos	180 days/180 days	12 mos/12 mos
OTHER EXCLUSIONS	care provided free of charge self inflicted injury/suicide mental, psychoneurotic, personality disorders outside U.S. war gov't nursing facilities	suicide self inflicted injury war mental disease disorder (w/o organic org. disease) care provided free of charge	outside U.S., Canada, Mexico war mental disorder (non organic) suicide self inflicted injury
WAIVER OF PREMIUM?	no	after 90 days for confine.	after 90 days
EVIDENCE OF INSURABILITY	short form medical	short form medical fully underwritten	short form medical
RENEWABILITY	group policy renewal	guaranteed lifetime	guaranteed renewable
POLICY FEE?	none	none	none
OTHER	10 day free look	10 day free look	10 day free look optional Extended Home Care Benefit

PREMIUM RATES (monthly cost for $40/day benefit - 20 day elimination period)

	50 - 59	$14.95			
65	60 - 64	$24.95	$15.00	60 - 64	$29.21*
65-69		$39.95	$29.00		
70-74		$64.95	$50.00	70 - 74	$92.90*
75-79		$94.95	$83.00		

*for $50/day benefit, 0 day elimination period

RATE BASIS	entry age (79 yr. max)	entry age (84 yr. max)

COMPARISON OF LONG TERM CARE POLICIES

CARRIER	UNITED EQUITABLE LIFE	FIREMAN'S FUND	ACCELERATION LIFE INS. CO.
SKILLED NURSING CARE			
DAILY BENEFIT	$50	$10-50	$20-60
TIME LIMITATION	4 years lifetime	4 years lifetime (all types)	1-3 years
RESTRICTIONS	stay begins within 30 days of a 3 day hospital stay; benefit paid if conf. in SNF, ICF, or cust. fac.; SNF = Medicare approved or qual to receive approval	stay begins within 90 days of a 3 day hospital stay	stay begins within 30 days of a 3 day hospital stay
INTERMEDIATE CARE			
DAILY BENEFIT	$50	$10-50	$20-60
TIME LIMITATION	4 years	4 years lifetime (all types)	1-3 years (all types)
RESTRICTIONS	stay begins within 30 days of 30 day covered SNF conf. for skilled care	care must be received in an SNF + initially was skilled care reduced to this level	stay begins within 30 days of 3 day hospital stay or within 24 hours of a 30 day SNF stay
CUSTODIAL CARE			
DAILY BENEFIT	$50	$10-50	$20-60
TIME LIMITATION	2 years	4 years lifetime (all types)	1-3 years (all types)
RESTRICTIONS	stay begins w/in 30 days of a 30 day covered confine. for skilled care	care must be received in an SNF + initially was skilled care reduced to this level	stay begins w/in 30 days of a 3 day hospital stay or w/in 24 hours of an SNF stay
HOME HEALTH			
DAILY BENEFIT	$50	50% of skilled ben.	$20-$60
TIME LIMITATION	2 years	180 days	1-3 years (all types)
RESTRICTIONS	benefit reduced by # days used up for custodial care service begins within 30 days of receipt of cust. care benefits	begin immed. after 180 paid days in SNF appears to be none; care may be received in the home and may be primarily residential care	service must begin within 30 days of a 3 day hospital stay
ELIMINATION PERIOD	0, 20, or 100 days	20 or 100 days	0 or 100 days
$ MAXIMUMS (if any)	lifetime = $60,000		Lifetime = $11,400 - $68,400

COMPARISON OF LONG TERM CARE POLICIES

CARRIER	UNITED EQUITABLE LIFE	FIREMAN'S FUND	ACCELERATION LIFE INS. CO
EXTENSIONS	during continuous confine	term by insurer. liability exists for losses within 90 days	
PRE EXISTING EXCLUSION	180 days/180 days	all/90 days	12 mos./6 mos.
OTHER EXCLUSIONS	suicide self inflicted injury nervous/mental diseases/ order (w/o demons. organic illness) dental (unless injury) outside U.S. war	suicide self inflicted injury nervous/mental disease/ disorder (w/o demons. organic illness) hospital confinements sanitor., V.A. or govt. institution	suicide self inflicted injury dental unless injury workers comp mental/nervous psychotic or psychoneurotic disorders plastic surgery unless injury war outside U.S.
WAIVER OF PREMIUM?	after 100 days for confine.	after 90 days for confine.	
EVIDENCE OF INSURABILITY	short form medical	short form medical	short form medical
RENEWABILITY	guaranteed lifetime	state basis	state basis
POLICY FEE?	$40.00	$15	$20.00
OTHER	10 day free look D&U Premium ded. from clm available in 45 states sold by agent	10 day free look D&U Premium ded. from clm worldwide coverage paid up provision sold by agent available in 8 states	choose 1,2, or 3 year max choose $10, $40, $60 benefits choose 1st or 101st day coverag

PREMIUM RATES (monthly cost for $40/day benefit - 20 day elimination period)

65	$33.65*	$27.50	$48.55
65-69	$33.65*	$40.00	$63.60
70-74	$54.25*	$47.20	$63.60
75-79	$77.35*	$68.00	$62.60

*Assumes 60% of days are for skilled care.

RATE BASIS	entry age (79 yr. max)	entry age (79 yr. max)	entry age (85 yr. max)

COMPARISON OF LONG TERM CARE POLICIES

CARRIER	AMERICAN REPUBLIC	MASSACHUSETTS INDEMNITY	FEDERATED AMERICAN LIFE
SKILLED NURSING CARE			
DAILY BENEFIT	$40	$50	$30
TIME LIMITATION	1500 days	none	4 years lifetime (all types)
RESTRICTIONS		stay begins within 28 days of a 3 day hospital stay	stay begins within 90 days of a 3 day hospital stay
		SNF licensed by the state	
INTERMEDIATE CARE			
DAILY BENEFIT	$40	$50	$30
TIME LIMITATION	1500 days	none	4 years lifetime (all types)
RESTRICTIONS		stay begins within 28 days of a 3 day hospital stay	stay begins within 90 days of a 3 day hospital stay
		SNF/ICF licensed by	care must be received in an SNF
		the state	initially was skilled care
CUSTODIAL CARE			
DAILY BENEFIT	$40	**NONE**	$30
TIME LIMITATION	1500 days		4 years lifetime (all types)
RESTRICTIONS			stay begins within 90 days of a 3 day hospital stay
			care must be received in an SNF
			initially was skilled care
HOME HEALTH			
DAILY BENEFIT	$20	**NONE**	**NONE**
TIME LIMITATION	26 weeks		
RESTRICTIONS	service must begin after a nursing home stay where benefits were paid for at least 90 days 3 visits/week max		
ELIMINATION PERIOD	90 days	60 days	20 days
$ MAXIMUMS (if any)		Lifetime = $75,000 (all benefits)	

COMPARISON OF LONG TERM CARE POLICIES

CARRIER	AMERICAN REPUBLIC	MASSACHUSETTS INDEMNITY	FEDERATED AMERICAN LIFE
EXTENSIONS			Same by insurers liab. exists For losses within 90 days
PRE-EXISTING EXCLUSION	all/6 months	1 year/1 year	all/30 days
OTHER EXCLUSIONS	suicide self-inflicted injury war mental/emotional disorder alcoholism/drug addiction hospital confinement care provided free of charge outside U.S.	suicide self inflicted injury nervous/mental disease/ disorder (w/o demons. organic illness) outside U.S. occupational injury covered by WC	suicide self inflicted injury nervous/mental disease/disorder (w/o demons. organic illness) hospital confinement sanitar., VA, or govt.
WAIVER OF PREMIUM?	after 90 days for confine.		after 90 days for confine.
EVIDENCE OF INSURABILITY	?	short form medical	short form medical
RENEWABILITY	guaranteed lifetime	group policy renewal	state basis
POLICY FEE?		none	$10
OTHER		this is a description of a policy issued in MN (their major marketing state)	10 day free look D&W Premium ded. from clm sold by agent
PREMIUM RATES (monthly cost for $40/day benefit-20 day elimination period)			
65	$37.00*	$ 9.50**	$18.90
65-69	$69.00*	$18.40**	$32.20
70-74	$110.00*	$32.85**	42.20
75-79	$142.00*	$42.40**	$48.90
		$65.35**	$48.90

*premiums reflect a 90 day waiting period, not 20
**60 day elimination period

RATE BASIS	entry age (75 yr. max)	attained age (no age limit)	entry age (84 yr. max)

COMPARISON OF LONG TERM CARE POLICIES

CARRIER	COLUMBIA LIFE INSURANCE	EQUITABLE LIFE & CASUALTY	MUTUAL PROTECTIVE (MEDICO)
SKILLED NURSING CARE			
DAILY BENEFIT	$10-50	$10-60	Days 1-20 = $6.12 Days 21-100 = $20.30
TIME LIMITATION	60 mos lifetime	24 mos. per confinement	Days 101- 4 yrs = $40.60
RESTRICTIONS	stay begins within 14 days of a 3 day hospital stay;	stay begins within 14 days of a 3 day hospital stay; SNF=Medicare approved or qual. to receive approval	stay begins within 14 days of a 3 day hospital stay; Doctor must certify level of care monthly
INTERMEDIATE CARE			
DAILY BENEFIT	$10-50	50% of skilled benefit	$10-20
TIME LIMITATION	optional 6 or 12 mos.	12 mos. per confinement	180 days lifetime
RESTRICTIONS	stay begins within 14 days of 14 day covered SNF stay	stay begins within 14 days of a 3 day hospital stay or within 14 days of covered SNF stay	stay begins within 14 days of a 3 day hospital stay or *med following 14 day covered SNF fac. holds lic. for 2nd highest level of inpatient nursing
CUSTODIAL CARE			
DAILY BENEFIT	$10-50	25% of skilled benefit	$5-10
TIME LIMITATION	optional 6 or 12 mos.	6 mos. per confinement	180 days lifetime
RESTRICTIONS	stay begins within 14 days of 14 day covered SNF stay	stay begins within 14 days of SNF or ICF covered stay of 30 days	stay begins immed. after covered SNF or ICF confine of 30 days
HOME HEALTH			
DAILY BENEFIT		12.5% of skilled benefit	$5-10
TIME LIMITATION	**NONE**	30 days per confinement immediately follows a 30 day day ICF or SNF stay (not cust.); homebound req.	# of days in hosp.*; from SNF/ICF = # days of combined stays*; no bene. if cust. paid; *max = 30 days per confine
ELIMINATION PERIOD	0, 20, 60 or 100 days	0, 10, or 100 days	none
$ MAXIMUMS (if any)		lifetime=$15,000-90,000	lifetime = $60,000-90,000

COMPARISON OF LONG TERM CARE POLICIES

CARRIER	COLUMBIA LIFE INSURANCE	EQUITABLE LIFE & CASUALTY	MUTUAL PROTECTIVE (MEDICO)
EXTENSIONS	during continuous confine.		
PRE-EXISTING EXCLUSION	5 yrs/6 mos. (other conditions as specified (sick occurring in 1st 30 days)	5 yrs/6 mos.	5 yrs/6 mos. (sick occurring in 1st 30 days)
OTHER EXCLUSIONS	suicide self inflicted injury func. nervous/mental disease/ disorder hospital confinement pregnancy	suicide self inflicted injury nervous/mental disease/dis order (w/o demons. organic illness dental outside U.S. war	suicide self inflicted injury nervous/mental disease/disorder (w/o demons. organic illness) hospital confinement chgs you would not have to pay if you had no insurance.
WAIVER OF PREMIUM	after 90 days for confine.		
EVIDENCE OF INSURABILITY	short form medical	short form medical	short form medical
RENEWABILITY	state basis	guaranteed lifetime	state basis
POLICY FEE?	$10 ($6 in KY)	$10	(not clear)
OTHER	10 day free look sold by agent	10 day free look D&U prem. ded. from clm. sold by agent available in 13 states	30 day free look Ambulance benefit ($25 after hosp. confine.) sold by agent
PREMIUM RATES (Monthly cost for $40/day benefit-20 day elimination period)			
65	$19.35	$20.75	$28.50
65-69	$26.00	$20.75	$28.50
70-74	$38.35	$32.60	$35.40
75-79	$ -- --	$48.15 $64.05	$35.40 $38.35
	based on 12 month int/cust. option		(based on days 21-100 benefit) (50% inc based on 1 unfav cond. 100% inc based on 2 unfav cond)
RATE BASIS	entry age (74 yr. max)	attained age (84 yr. max)	attained age (84 yr. max)

COMPARISON OF LONG TERM CARE POLICIES

CARRIER	BLUE CROSS OF NORTH DAKOTA
SKILLED NURSING CARE	
DAILY BENEFIT	$35
TIME LIMITATION	630 days (all types)
RESTRICTIONS	Nonparticipating provider = 80% Reduction in payment to participating provider if insufficient funds
INTERMEDIATE CARE	
DAILY BENEFIT	
TIME LIMITATION	630 days (all types)
RESTRICTIONS	Nonparticipating provider = 80%; Reduction in payment to participating provider if insufficient funds
CUSTODIAL CARE	
DAILY BENEFIT	
TIME LIMITATION	""NONE""
RESTRICTIONS	
HOME HEALTH	
DAILY BENEFIT	
TIME LIMITATION	""NONE""
RESTRICTIONS	
ELIMINATION PERIOD	100 days (one time)
$ MAXIMUMS (if any)	

COMPARISON OF LONG TERM CARE POLICIES

CARRIER	BLUE CROSS OF NORTH DAKOTA
EXTENSIONS	
PRE-EXISTING EXCLUSION	all/180 days
OTHER EXCLUSIONS	services that could be provided in a lesser care facility or at home any days that qualify for SNF benefits under Medicare or a SC Hospital Service contract
WAIVER OF PREMIUM	
EVIDENCE OF INSURABILITY	short form medical clm exp of current BC insureds
RENEWABILITY	
POLICY FEE?	
OTHER	10 day free look sold by agent provider pays BCND a one time payment of $20/bed
PREMIUM RATES (monthly cost for $40/day benefit - 20 day elimination period)	
65	$40.95
65-69	$51.35
70-74	$55.45
75-79	$64.15
	$76.20
	(above rates if subscriber also carries BC Medicare Extended or other plan) If subscriber carries BC Regular Cov., rates = $12.20 for all ages
RATE BASIS	attained age (no max)

Guide to Health Insurance for People with Medicare

1987

Some Basic Things
You Should Know

Hints on Shopping for
Private Health Insurance

Types of Private
Health Insurance

What Medicare Pays and
Doesn't Pay

COMPLIMENTS OF

Mutual of Omaha Companies

People you can count on...

Compliments of:

Mutual of Omaha Insurance Company
Home Office: Omaha, Nebraska

U.S. Department of
Health and Human
Services

Health Care
Financing
Administration

HCFA02110 1-87
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Developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration of the U.S. Department of Health and Human Services.

SOME BASIC THINGS YOU SHOULD KNOW

Medicare pays a large part of your health care expenses. It does not pay them all. There are limits on some covered services and you must pay certain amounts called deductibles and co-payments.

Medicare does not cover some services at all. Neither does most private insurance, for example:

- What many people think of as nursing home care is not usually covered by Medicare or insurance policies on the market today. (See page 3.)
- Medicare and most private health insurance policies pay only a specified percent of the amount approved by Medicare. You pay the rest. To avoid extra charges, ask your doctor if he or she participates or accepts assignment of Medicare benefits. Assignment means that your doctor (or other supplier) agrees to accept the amount approved by Medicare as the total charge for covered services and supplies. Participating doctors or suppliers accept assignment on all Medicare claims. (See page 5.)
- Insurance to supplement Medicare is not sold or serviced by the government. Do not believe advertising or agents who suggest that Medicare supplement insurance is a government-sponsored program.

Before you consider buying insurance to supplement Medicare, you should know what Medicare benefits are. Pages 4 through 7 explain your Medicare coverage. Please review them carefully.

DO YOU NEED PRIVATE HEALTH INSURANCE IN ADDITION TO MEDICARE?

Not everyone does...

- Low-income people who are eligible for Medicaid generally do not need additional insurance. Medicaid pays almost all costs including long-term nursing care. Contact your local social service agency to find out if you qualify and what the benefits are in your state.
- Whether you need health insurance in addition to Medicare is a decision which you should discuss with someone you know who understands insurance and your financial situation. The best time to do this is before you reach age 65.

HINTS ON SHOPPING FOR

Shop Carefully Before You Buy...policies differ widely as to coverage and cost, and companies differ as to service. Contact different companies and compare the policies carefully before you buy.

Don't Buy More Policies Than You Need... duplicate coverage is costly and not necessary. A single comprehensive policy is better than several policies with overlapping or duplicate coverages. For comprehensive coverage, consider continuing the group coverage you have at work; joining an HMO; buying a catastrophic or major medical policy or buying a Medicare Supplement policy. (See page 3.)

Check For Preexisting Condition Exclusions... which reduce or eliminate coverage for existing health conditions. Many policies exclude coverage for preexisting health conditions.

Don't be misled by the phrase "no medical examination required." If you have had a health problem, the insurer might not cover you for expenses connected with that problem.

Beware of Replacing Existing Coverage...be suspicious of a suggestion that you give up your policy and buy a replacement. Often the new policy will impose waiting periods or will have exclusions or waiting periods for preexisting conditions your current policy covers. On the other hand, don't keep inadequate policies simply because you have had them a long time. You don't get credit with a company just because you've paid many years for a policy.

Be Aware of Maximum Benefits...most policies have some type of limit on benefits which may be expressed in terms of dollars payable or the number of days for which payment will be made.

PRIVATE HEALTH INSURANCE

Check Your Right To Renew . . . beware of policies that let the company refuse to renew your policy on an individual basis. These policies provide the least permanent coverage.

Most policies cannot be canceled by the company unless all policies of that type are canceled in the state. Therefore, these policies cannot be canceled because of claims or disputes. Some policies are guaranteed renewable for life. Policies that can be renewed automatically offer added protection.

Policies to Supplement Medicare Are Neither Sold nor Serviced by State or Federal Government . . . State Insurance Departments approve policies sold by insurance companies but approval only means the company and policy meet requirements of state law. Do not believe statements that insurance to supplement Medicare is a government-sponsored program. If anyone tells you that he or she is from the government and later tries to sell you an insurance policy, report that person to your State Insurance Department. (This type of representation is a violation of Federal Law.)

Know With Whom You're Dealing . . . a company must meet certain qualifications to do business in your state. This is for your protection. Agents also must be licensed by your state and must carry proof of licensing showing their name and the company they represent. If the agent cannot show such proof, do not buy from that person. A business card is not a license.

Keep Agents' and/or Companies' Names, Addresses and Telephone Numbers . . . write down the agents' and/or companies' names, addresses and telephone numbers or ask for a business card.

Take Your Time . . . do not let a short-term enrollment period high pressure you. Professional salespeople will not rush you. If you question whether a program is worthy, ask the salesperson to explain it to a friend or relative whose judgment you respect. Allow yourself time to think through your decision.

IF YOU DECIDE TO BUY

Complete Application Carefully . . . some companies ask for detailed medical information. If they do and you omit the requested medical information, the company can refuse coverage for an omitted condition for a period of time or it may deny a claim and/or cancel your policy. Do not believe anyone who tells you that your medical history on an application is not important.

Look for an Outline of Coverage . . . you should be given a clearly worded summary of the policy . . . READ IT CAREFULLY.

Do Not Pay Cash . . . pay by check, money order or bank drafts made payable to the insurance company, not the agent or anyone else.

Check For A Free-Look Provision . . . most companies give you at least 10 days to review the policy. If you decide you don't want to keep it, send it back to the agent or company within 10 days of receiving it and you will get a refund of all premiums you have paid.

Policy Delivery or Refunds Should Be Prompt . . . the insurance company should deliver a policy within 30 days. If not, contact the company and obtain in writing a reason for failure to deliver. If 60 days go by without information, contact your State Insurance Department. The same schedule should be followed if you return the policy but do not receive your refund.

For Your Protection . . . Federal criminal penalties can be imposed against any company or agent who knowingly sells you a policy that duplicates Medicare coverage or any private health insurance that you already own but which will not pay duplicate benefits, or suggests that they represent the Medicare program or any Government agency. If you believe you have been the victim of any of these, or any other illegal sales practices, you should contact your State Insurance Department.

WHAT MEDICARE PAYS AND DOESN'T PAY

Medicare is divided into two parts — hospital insurance (Part A) and medical insurance (Part B). Page 4 describes Part A benefits and page 5 describes Part B benefits. The chart on page 6 gives brief outlines of both Part A and Part B. Please refer to **Your Medicare Handbook** or any Social Security Office for more information.

Medicare does not pay the entire cost for all covered services. You pay for deductibles and co-payments. A deductible is an initial dollar amount which Medicare does not pay . . . a co-payment is your share of expenses for covered services above the deductible.

TYPES OF PRIVATE HEALTH INSURANCE

Private health insurance is available through group and individual policies. It is offered by some companies through agents and by other companies directly through advertising media and mail. Coverages offered and their values differ widely among both group and individual policies.

Types of individual and group health insurance coverages:

- **Medicare Supplement**...pays some or all of Medicare's deductibles and co-payments. Some policies may also pay for some health services not covered by Medicare.

  Medicare pays only for services determined to be medically necessary and only to the extent of what Medicare determines to be the approved amount (see pages 4 through 7). Most Medicare supplements follow the same guidelines and pay nothing for services Medicare finds unnecessary.

- **Catastrophic or Major Medical Expense**...helps cover the high cost of serious illness or injury, including some health services not covered by Medicare. These policies usually have a large deductible and may not cover Medicare's co-payments and deductibles. If this type policy is available in your area, it can be a better dollar value to insure only for catastrophic expenses than to buy coverage for the Medicare deductibles and co-payments.

- **Health Maintenance Organizations (HMOs)**...there may be one or more HMOs in your area which participate in the Medicare program. HMOs both insure health care and provide the service. People who join HMOs pay a membership fee, or premium, and then receive health services directly from physicians and other providers affiliated with HMOs. Services are prepaid, so there are usually no claims forms to process. For Medicare covered services, there are usually no separate charges for deductibles or co-payments. If you are willing to receive your care from a specified group of providers, HMOs may provide the most complete service for your health care dollar.

Group insurance is available through employers and through voluntary associations.

- **Employer Group Insurance**...many people are covered by a group plan while they are employed. Find out before you retire if your group coverage can be continued or converted to a suitable individual Medicare supplement policy when you reach age 65. Check carefully the price and the benefits, including benefits for your spouse. Employer continued or conversion group insurance usually has the advantage of having no waiting periods or preexisting condition exclusions. Consult your employer for information about special rules that apply to employer group coverage for people who continue to work after they reach age 65.

- **Association Group Insurance**...many organizations, other than employers, offer various kinds of group health insurance coverage to their members over age 65.

Beware of claims of low group rates because coverage under group policies may be as expensive or more costly than comparable coverage under individual policies. Be sure you understand the benefits included and then compare prices.

The following coverages are limited in scope and are not substitutes for Medicare Supplement, Castastrophic, Major Medical Expense or HMOs.

- **Nursing Home Coverage**...usually pays a stated amount a day for required skilled nursing service furnished in a skilled nursing facility. Intermediate care, rest care and custodial care are generally not covered under any policy on the market today. Most people in nursing homes are receiving custodial care. Be sure you know which nursing homes and services are covered.

- **Hospital Confinement Indemnity Coverage**...pays a fixed amount for each day you are hospitalized up to a designated number of days. Some coverage may have added benefits such as surgical benefits or skilled nursing home confinement benefits. Premiums do not ordinarily increase, but the fixed benefits do not rise to meet increasing costs of hospitalization.

- **Specified Disease Coverage** (not available in some states)...provides benefits for only a single disease, such as cancer, or a group of specified diseases. The value of such coverage depends on the chance you will get the specific disease or diseases covered. Benefits are usually limited to payment of a fixed amount for each type of treatment. Benefits are not designed to fill the Medicare gaps.

MEDICARE HOSPITAL INSURANCE BENEFITS (PART A)

WHAT MEDICARE PART A PAYS

When all program requirements are met, Medicare Part A will help pay for medically necessary in-hospital care, for medically necessary inpatient care in a skilled nursing facility after a hospital stay, and for hospice care. In addition, Part A pays the full cost of medically necessary home health care.

Part A covers all services customarily furnished by hospitals and skilled nursing facilities. Part A does not cover private duty nursing, charges for a private room unless medically necessary, or convenience items such as telephones or television. Part A also does not cover the first 3 pints of blood you receive during an inpatient stay (but you cannot be charged for blood if it is replaced by a blood plan or through a blood donation in your behalf).

BENEFIT PERIODS

Medicare Part A benefits are paid on the basis of benefit periods. A benefit period begins the first day you receive Medicare covered service in a hospital and ends when you have been out of a hospital or skilled nursing facility for 60 days in a row. If you enter a hospital again after 60 days, a new benefit period begins. All Part A benefits (except for lifetime reserve days you have used) are renewed. There is no limit to the number of benefit periods you can have for hospital or skilled nursing facility care. However, special limited benefit periods apply to hospice care.

INPATIENT HOSPITAL CARE

Part A pays for all covered services for the first 60 days of inpatient hospital care in a benefit period except for $520, the 1987 Part A deductible. For the next 30 days, Part A pays for all covered services except for $130 a day. Every person enrolled in Part A also has a 60-day reserve for inpatient hospital care which can be drawn from if more than 90 days are needed in a benefit period. When reserve days are used, Part A pays for all covered services except for $260 a day. Once used, reserve days are not renewable.

SKILLED NURSING FACILITY CARE

A skilled nursing facility is a special kind of facility which primarily furnishes skilled nursing and rehabilitation services. It may be a separate facility or a part of a hospital. Medicare benefits are payable only if the skilled nursing facility is certified by Medicare. Most nursing homes in the United States are not skilled nursing facilities and many skilled nursing facilities are not certified by Medicare.

Part A pays for all covered services for the first 20 days of medically necessary inpatient skilled nursing facility care during a benefit period. In 1987, for the next 80 days, Part A pays all except $65 a day.

Medicare Part A will not cover your stay in a skilled nursing facility if the services you receive are mainly personal care or custodial services, such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine.

HOME HEALTH CARE

Part A pays the cost of all medically necessary home health visits. Part A covers part-time services of a visiting nurse or physical or speech therapist from a Medicare certified home health agency. If you receive any of these services, Part A can also cover part-time home health aide services, occupational therapy, medical social services and medical supplies and equipment. Part A does not cover full-time nursing care, drugs, meals delivered to your home or homemaker services that are primarily to assist you in meeting personal care or housekeeping needs.

HOSPICE CARE

Under certain conditions, Part A can pay for hospice care for people who have a terminal illness. Part A can pay for a maximum of two 90-day hospice benefit periods and one 30-day period. During a hospice benefit period, Part A pays the full cost of all medical and support services necessary for the symptom management and pain relief of a terminal illness. Covered services include the following, when provided by a Medicare certified hospice: physician services, nursing care, medical appliances and supplies (including outpatient drugs for symptom management and pain relief), short-term inpatient care, counseling, therapies, and home health aide and homemaker services. There are no deductibles or co-payments except for limited cost sharing for outpatient drugs and inpatient respite care.

MEDICARE MEDICAL INSURANCE BENEFITS (PART B)

WHAT MEDICARE PART B PAYS

Medicare Part B helps pay for doctors' bills and many other medical services. You are automatically enrolled in Part B when you enroll in Medicare Part A . . . although you may state that you don't want it. In 1987, the Part B premium is $17.90 a month. This amount may change each January 1. YOU DON'T HAVE TO PURCHASE PART B . . . BUT IT IS AN EXCELLENT BUY BECAUSE THE FEDERAL GOVERNMENT PAYS ABOUT THREE QUARTERS OF THE ACTUAL COST.

You pay the first $75 of approved charges in 1987. (This is the 1987 Part B deductible.) After that, Medicare Part B generally pays 80% of the amount Medicare approves for covered services you receive the rest of the year. You pay the remaining 20%. This is the Part B co-payment. Unless your doctor or supplier accepts assignment (see explanation below), you are responsible for charges above the amount Medicare approves.

SERVICES COVERED

- Physicians' and surgeons' services no matter where you receive them . . . at home, in the doctor's office, in a clinic or in a hospital. Routine physical exams are excluded.
- Home health visits. Medicare pays the full cost of medically necessary home health visits. You have no deductible or co-payment.
- Physical therapy and speech pathology services, in a doctor's office or as an outpatient and, on a limited basis, in your home.
- Other medical services and supplies . . . such as outpatient hospital services; X-rays and laboratory tests; certain ambulance services; and purchase or rental of durable medical equipment, such as wheelchairs.

Part B will not pay for any services which Medicare does not consider medically necessary . . . neither will most insurance policies.

APPROVED AMOUNT

In deciding whether a charge is reasonable, Medicare reviews each year the usual charge by the doctor or supplier for each covered service, and the charge of other doctors and suppliers in the area for the same service. The amount approved is often lower than the actual charge made by the doctor or supplier.

Most insurance policies you can buy to supplement Medicare only pay 20% of Medicare's approved amount. You might not get 100% coverage for your Part B bills even if you have Medicare Part B and private insurance. Here's how this could happen.

Suppose your doctor charges you $400 for an operation and Medicare determines the approved amount to be $300. Assuming you have already met the annual Part B deductible, Medicare would pay 80% of the $300, or $240. Most insurance policies would pay 20% of the $300, or $60. You would pay $100 — the difference between your doctor's actual charge and Medicare's approved amount. However, you may avoid this extra payment if your doctor accepts assignment.

ASK ABOUT ASSIGNMENT AND PARTICIPATING DOCTORS OR SUPPLIERS

Because you can't tell in advance whether the approved amount and the actual charge will be the same, always ask your doctors or other medical suppliers, such as laboratories and therapists, if they will accept assignment of Medicare benefits. Assignment means that the doctor or supplier will accept Medicare's approved amount as full payment and cannot legally bill you for anything above that amount. In the example above, if your doctor agreed to assignment, he or she would accept $300 as payment in full and you would not have to pay the $100 difference yourself. Doctors and suppliers do not have to accept assignment, but many do.

Also, doctors and suppliers can now become Medicare-participating doctors or suppliers who agree to accept assignment on all Medicare claims. These doctors and suppliers are listed in the **Medicare Participating Physician/Supplier Directory** which is distributed to senior citizen organizations, all Social Security and Railroad Retirement offices, and all State and area offices of the Administration on Aging. This directory can be purchased from the insurance carrier that processes Medicare Part B claims in your area (see the back of **Your Medicare Handbook** for the list of carrier addresses) or you can call the carrier to find out which doctors and suppliers are participating.

MEDICARE (PART A): HOSPITAL INSURANCE — COVERED SERVICES PER BENEFIT PERIOD (1)

SERVICE	BENEFIT	MEDICARE PAYS**	YOU PAY**
HOSPITALIZATION... Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but $520	$520
	61st to 90th day	All but $130 a day	$130 a day
	91st to 150th day*	All but $260 a day	$260 a day
	Beyond 150 days	Nothing	All costs
POSTHOSPITAL SKILLED NURSING FACILITY CARE... In a facility approved by Medicare. You must have been in a hospital for at least 3 days and enter the facility within 30 days after hospital discharge. (2)	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but $65 a day	$65 a day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE	Visits limited to medical necessity	Full cost	Nothing
HOSPICE CARE	Two 90-day periods and one 30-day period	All but limited costs for outpatient drugs and inpatient respite care	Limited cost sharing for outpatient drugs and inpatient respite care
BLOOD	Blood	All but first 3 pints	For first 3 pints

*60 Reserve Days may be used only once; days used are not renewable.
**These figures are for 1987 and are subject to change each year.
(1) A Benefit Period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital or skilled nursing facility for 60 days in a row.
(2) Medicare and private insurance will not pay for most nursing home care. You pay for custodial care and most care in a nursing home.

MEDICARE (PART B): MEDICAL INSURANCE — COVERED SERVICES PER CALENDAR YEAR

SERVICE	BENEFIT	MEDICARE PAYS	YOU PAY
MEDICAL EXPENSE Physician's services, inpatient and outpatient medical services and supplies, physical and speech therapy, ambulance, etc.	Medicare pays for medical services in or out of hospital. Some insurance policies pay less (or nothing) for hospital outpatient medical services or services in a doctor's office	80% of approved amount (after $75 deductible)	$75 deductible* plus 20% of balance of approved amount (plus any charge above approved amount)**
HOME HEALTH CARE	Visits limited to medical necessity	Full cost	Nothing
OUTPATIENT HOSPITAL TREATMENT	Unlimited as medically necessary	80% of approved amount (after $75 deductible)	Subject to deductible plus 20% of balance of approved amount
BLOOD	Blood	80% of approved amount (after $75 deductible and starting with 4th pint)	For first 3 pints plus 20% of balance of approved amount (after $75 deductible)

*Once you have had $75 of expense for covered services in 1987, the Part B deductible does not apply to any further covered services you receive the rest of the year.
**YOU PAY FOR charges higher than amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as the total charge for services rendered. (See page 5.)

EXPENSES NOT COVERED BY MEDICARE

Medicare does not cover certain kinds of care. Most private insurance does not cover them either. Among them are:

- Private duty nursing.
- Skilled nursing home care costs (beyond what is covered by Medicare).
- Custodial nursing home care costs.
- Intermediate nursing home care costs.
- Physician charges (above Medicare's approved amount).
- Drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay or outpatient drugs for symptom management or pain relief provided by a hospice).
- Care received outside the U.S.A., except under certain conditions in Canada and Mexico.
- Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for and the cost of eyeglasses or hearing aids.

FOR ADDITIONAL HELP...

If you need additional help or advice on Medicare benefits or eligibility, contact your nearest Social Security Office or the Health Care Financing Administration. For information on private insurance to supplement Medicare, check with your State Insurance Department or State Consumer Protection Agency.

If you bought or are considering buying a health insurance policy, the company or its agent should answer your questions. If you do not get the service you feel you deserve, discuss the matter with your State Insurance Department.

THE MEDICARE INFORMATION IN THIS PAMPHLET IS FOR 1987. IT WILL CHANGE FROM YEAR TO YEAR. FOR A MORE DETAILED AND CURRENT EXPLANATION OF MEDICARE AND ITS BENEFITS, OBTAIN A FREE COPY OF **A BRIEF EXPLANATION OF MEDICARE** FROM YOUR LOCAL SOCIAL SECURITY OFFICE.

No. 783. Money Income of Persons—Percent Distribution by Income Level, Median, and Mean Income, by Sex, 1960 to 1983, and by Race, Spanish Origin, Region, and Age, 1983

[For 1960–1975, persons 14 years old and over; thereafter, 15 years old and over. As of March of following year. Based on Current Population Survey; see headnote, table 751. For definitions of median and mean, see Guide to Tabular Presentation. See *Historical Statistics, Colonial Times to 1970*, series G 257–[illegible], for percent distribution by income level, and median income]

Sex, year, race, Spanish origin, region, and age	All persons (mil.)	Persons with income										
		Total (mil.)	Percent distribution by income (in dollars) level—								Median income (dol.)	Mean income (dol.)
			1 to 1,999 or less [1]	2,000–3,999	4,000–5,999	6,000–7,999	8,000–9,999	10,000–14,999	15,000–24,999	25,000 and over		
Males												
1960	80.4	55.2	27.8	21.4	24.7	14.7	5.5	4.1	1.4	.8	4,080	4,817
1970	70.8	66.0	18.8	13.7	12.8	14.7	13.2	17.7	8.8	2.3	6,670	7,537
1975	77.8	71.2	12.9	12.0	10.8	10.0	9.6	21.7	17.8	5.4	8,953	10,429
1979	80.2	76.5	9.5	8.2	8.4	8.3	7.0	17.8	25.7	14.1	11,846	14,368
1980	82.9	78.7	9.1	8.0	8.2	7.8	6.9	17.1	25.5	17.5	12,530	16,340
1981	84.0	79.7	8.9	7.8	7.6	7.5	6.8	15.8	24.5	21.4	13,473	18,515
1982	85.0	79.7	9.1	7.8	7.3	7.2	6.1	16.0	23.8	23.8	13,950	17,381
1983	86.1	80.9	9.0	6.9	6.9	7.0	5.9	15.2	23.2	25.8	14,831	18,109
White	75.0	71.4	8.4	6.3	6.8	12.6		15.0	23.8	27.3	15,401	18,823
Black	9.0	7.8	14.1	12.8	10.0	18.2		17.2	18.5	11.2	8,987	11,501
Spanish origin [2]	4.8	4.2	9.0	7.8	9.8	17.1		20.8	22.3	13.2	11,278	13,450
Northeast	18.5	17.2	8.8	6.3	6.7	12.1		14.7	23.8	27.5	15,474	18,639
Midwest	21.6	20.4	10.2	6.8	6.8	12.2		14.3	23.9	25.8	14,870	17,848
South	26.9	27.2	8.8	7.9	7.5	14.2		16.2	22.5	23.1	13,378	17,301
West	17.1	16.0	8.6	6.0	6.4	12.4		15.0	23.1	26.5	15,564	19,244
15–19 years	8.3	6.3	57.7	20.8	10.0	7.3		3.0	1.1	.1	1,795	2,804
20–24 years	10.4	9.8	15.0	13.8	11.8	21.4		20.0	14.8	3.8	7,851	8,998
25–34 years	19.9	19.3	4.1	4.5	5.0	11.1		19.1	32.4	24.7	18,906	19,290
35–44 years	14.7	14.5	3.2	3.0	3.1	7.0		12.0	29.1	43.6	22,440	25,234
45–54 years	10.7	10.5	3.8	3.2	3.4	7.8		11.3	25.1	45.9	23,115	26,222
55–64 years	10.3	10.1	4.0	4.0	5.4	11.7		14.7	25.3	34.9	19,894	22,765
65 yr. old and over	10.7	10.7	2.2	5.5	14.5	34.2		21.1	17.4	10.1	9,796	13,158
Females												
1960	85.3	36.5	62.8	25.0	9.8	1.9	.2	.2			1,261	1,861
1970	77.8	51.8	46.7	22.1	15.7	8.8	3.8	2.5	.4	.2	2,237	3,139
1975	85.0	60.8	31.9	24.0	15.4	11.2	7.3	7.9	2.2	.3	3,385	4,513
1979	88.0	78.2	28.0	19.5	12.7	11.3	7.8	12.7	6.7	1.2	4,354	6,032
1980	91.1	80.8	24.8	18.8	13.3	10.3	7.9	14.2	9.0	1.9	4,920	6,772
1981	92.2	82.1	22.8	17.2	13.4	10.0	7.9	15.0	10.9	2.7	5,458	7,440
1982	93.1	82.5	21.7	15.9	13.1	9.9	7.8	15.1	12.7	3.9	5,887	8,195
1983	94.3	83.8	20.7	14.7	12.9	9.8	7.4	15.4	14.0	5.2	6,319	8,780
White	81.0	72.8	21.2	14.0	12.7	17.1		15.5	14.3	5.3	6,421	8,885
Black	10.9	91.1	18.6	21.4	14.9	17.2		14.3	12.2	3.5	5,543	7,872
Spanish origin [2]	5.4	41.0	22.0	17.2	14.9	19.4		13.9	10.0	2.8	5,402	7,199
Northeast	20.7	19.8	19.8	14.0	14.2	17.1		15.5	14.1	5.3	6,390	8,870
Midwest	23.4	21.3	22.0	15.0	13.5	17.2		14.5	13.5	4.5	5,964	8,355
South	32.0	27.8	20.9	16.4	11.9	17.1		15.5	13.4	4.7	6,167	8,572
West	19.1	18.1	19.8	12.5	12.8	18.8		16.0	15.7	6.7	6,954	9,589
15–19 years	8.2	5.8	59.7	21.3	10.2	6.2		2.1	.4	.1	1,875	2,271
20–24 years	10.8	9.3	20.6	17.2	14.3	21.9		18.1	7.3	.5	5,892	6,841
25–34 years	20.3	18.4	20.2	8.7	9.1	18.2		18.9	20.2	5.7	8,503	10,021
35–44 years	15.3	14.0	20.7	10.1	7.8	15.3		17.1	19.8	9.1	8,850	10,871
45–54 years	11.5	10.3	21.2	10.4	8.9	18.2		17.1	18.5	7.8	8,205	10,307
55–64 years	11.9	10.7	21.4	18.0	11.9	18.1		14.8	13.9	6.0	6,129	9,033
65 yr. old and over	15.5	15.3	8.7	23.1	25.8	32.2		12.2	7.7	3.4	5,598	7,951

[1] Includes persons with income deficit. [2] Persons of Spanish origin may be of any race.

Source: U.S. Bureau of the Census, *Current Population Reports*, series P-60, No. 146.

No. 784. Median Money Income of Year-Round Full-Time Workers With Income, by Sex and Age: 1970 to 1983

[Age as of March of following year. Refers to civilian workers. For definition of median, see Guide to Tabular Presentation]

Age	Women					Men				
	1970	1975	1980	1982	1983	1970	1975	1980	1982	1983
Total with income	95,440	87,719	[1] 811,591	[1] 913,883	[1] 14,479	88,184	813,144	[1] 819,173	[1] 821,885	[1] 22,609
14–19 years	3,783	4,588	[2] 6,779	[2] 7,879	[2] 7,867	3,950	5,857	[2] 7,753	[2] 8,475	[2] 8,204
20–24 years	4,926	6,598	9,407	10,843	11,062	6,855	9,521	12,109	12,530	12,822
25–34 years	5,923	8,401	12,190	14,375	15,062	9,126	12,777	17,724	20,031	20,584
35–44 years	5,531	8,084	12,236	14,918	15,639	10,258	14,730	21,777	25,131	25,852
45–54 years	5,588	7,980	12,118	14,180	15,128	9,931	14,808	22,323	25,424	26,939
55–64 years	5,488	7,785	11,931	14,377	15,124	9,071	13,518	21,053	24,758	25,603
65 years and over	4,884	7,250	12,342	14,750	15,091	6,754	11,801	17,307	20,842	22,119

[1] Beginning 1980, restricted to 15 years old and over. [2] Beginning 1980, restricted to 15 to 19 years.

Source: U.S. Bureau of the Census, *Current Population Reports*, series P-60, No. 146, and earlier issues.

STATISTICAL ABSTRACT 1986